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REFORMING OUR NATION'S HEALTH CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINATION OF THE PROPER REFORMS TO BE MADE IN THE HEALTH CARE SYSTEM OF THE NATION TO MAKE HEALTH CARE BOTH AFFORDABLE AND AVAILABLE TO EVERYONE

OCTOBER 15, 1984

TULSA, OK

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REFORMING OUR NATION'S HEALTH CARE SYSTEM

MONDAY, OCTOBER 15, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Tulsa, OK.

The committee met at 10 a.m., in the State Office Building Auditorium, 440 South Houston, Tulsa, OK, Senator Don Nickles presiding.

Present: Senators Nickles and Durenberger.

OPENING STATEMENT OF SENATOR NICKLES

Senator NICKLES. We are pleased that you are here, especially so many of you who have come from some distance. Let's have a show of hands for a better idea of how many people are from the Tulsa area? How many outside of the Tulsa area? How many outside of the Tulsa area more than 40 miles? More than 100 miles?

I think you will notice there are a lot of people who have an interest from across the State on these issues.

There are very few areas which affect all of us more directly than health care. It is virtually certain that each of us will see a doctor and spend some time in a hospital at some point in our lifetime. For that reason, I believe that today is very important because we are talking about the future of our Nation's health care system and how to make the right reforms so that it will be both affordable and available to each of us, not just today but also in the future.

It is not an understatement to say that the health care industry is undergoing a revolution. The Nation has gone from spending $4 billion on health care in 1940 to $322 billion in 1982. As a percentage of our GNP, it has gone from 4 percent to over 10 percent in that same period. At this point, the future promises much of the same. The Department of Health and Human Services predicts that national spending for health care could increase to almost $700 billion by the year 1990.

The revolution is not just in how much is being spent on health care, but also in how that care is being financed. Before the advent of Federal programs like Medicare and Medicaid in 1966, only 26 percent of the country's total health bill was paid with tax dollars. The rest was paid by private citizens through insurance coverage and their own personal resources. In 1966, with the enactment of Medicare and Medicaid programs to provide health care to the elderly and poor, Government assumed a new role in ensuring access to health care.

The result was dramatic, albeit somewhat predictable. The intended relief for the private paying patient was achieved. The individual's share of the health care bill went down from 44 percent to 28 percent in 1982. On the other hand, Government's share for the health care bill was almost the exact opposite, going from 26 percent in 1965 to 42 percent in 1982. With the good news, better access to health care, has also come some bad news. To get straight to the point, we are having trouble paying for what was promised.

In 1966, when Medicare began, the employer and employee were each taxed 0.35 percent of their income which was then paid into the trust fund. That rate is now 1.3 percent and is scheduled to increased to 1.35 percent in 1985, and again to 1.45 percent in 1986. In addition, general revenues—not just trust fund dollars—are also paying for a portion of the Medicare Program, Part B Supplementary Insurance Program. Even with the tax increases already scheduled for 1985 and 1986, actuaries now report that we do not have enough to keep the trust fund solvent. The 1984 trustee's report said that the trust fund could be bankrupt by as soon as 1991. That is not very far off if Congress expects to do something without affecting current beneficiaries.

It is important we address these problems now, instead of waiting until they bloom as a very critical emergency right before us.

The challenge before Congress is the same one that faces everyone here today—the State in paying for its share of the Medicaid Program, private employers in paying for health care benefits for their employees, and private citizens in paying their bills. The uniqueness of the Government's situation is that it is the single largest purchaser of health care in the United States with Medicare alone accounting for 18 percent of national health care spending. It is certain that whatever Congress does with this program will have a major impact on the rest of the health care industry, both public and private.

Indeed, we have already seen the ripple effect of the recently passed prospective payment system. In perhaps the single most significant change to Medicare since its enactment, Congress changed the way it pays hospitals for Medicare patients. No longer does a hospital submit a bill representing its costs and the Federal Government pays it. Rather, now hospitals know on a prospective basis how much the Government will pay for each case. The old system was said to encourage hospitals to inflate their costs so that the Federal Government would then pay them more per case. Under the new system, the hospitals have an incentive to bring their costs below the Government rate and thus pocket the extra payment.

Since Congress passed this new payment system, States, the private sector, and the health care industry have been making changes to complement this system. Today we will hear about some of those changes. In addition, it is my hope that today will be for an exchange of ideas. I believe that the private sector may have some innovations and strategies which the Federal Government can adopt. The health industry representatives that we will hear from today can offer some guidance on where Congress ought to be steering the health care ship to keep it on a wise course. And our very distinguished guest, whom I am delighted to introduce in just

a moment, can give all of us the benefit of his expertise on what improvements and changes are imminent.

There is no doubt but that the United States has the very best health care system in the world. Our common goal is to keep it that way. It is evident that the system must be changed. It is not enough to just keep fueling the machine by raising taxes, true reforms are necessary. My personal aim is to make those changes fair and sound, not just for the next 3 to 5 years, but also for our children and grandchildren.

It is also very much my pleasure to have join us today my distinguished colleague, Hon. Senator David Durenberger from the State of Minnesota. Senator Durenberger has an interest, not only has an interest, but he has a leadership role to play in the Senate and has been playing that role for the last several years. He was elected to the U.S. Senate in 1978, I believe, and has done an outstanding job I think for for the State of Minnesota and also for our country. He is the chairman of the Health Care Subcommittee and Finance which deals with Medicare, Medicaid, and also Social Security and other related issues.

So, Senator Durenberger, as you can tell from the participation from the audience, there is a lot of interest in health care in Oklahoma. We are delighted that you would take time from your very busy schedule to be here. And I can tell you from firsthand experience that these times prior to, and particularly before election, are very busy times and it is a sacrifice to take time out of your State and join us in Oklahoma. Welcome to Oklahoma.

Senator DURENBERGER. Thank you, Don.

Because I am chairman of the Finance Subcommittee and the Finance Committee that deals with Medicare and Medicaid, when I see the show of hands about how far everybody has come, I have the feeling in Oklahoma you will come a long way for a lynching. I am down here because you play better football than we play in the Big Ten.

I am going to be very brief, although the subject and the size of the crowd really excites me. And I could spend a great deal of time trying to share with you a prospective that comes not—it starts in Minnesota because that is where I learned something about public policy before I went to the U.S. Senate, but it has been amplified by quite a number of visits like this around the country. But let me start where everything should start today with something near the end of Don Nickles' presentation.

Let me say we have been blessed, when the people of this country started using what we have always considered the minority parties, in other words, the one that we belong to, as a way to sort of change things, they started in Minnesota. And they elected two Republican Senators up there in 1978, elected me to replace Hubert Humphrey after his untimely death, and Rudy Boschwitz to replace Fritz Mondale. And that is all I am going to say about that.

But that sort of thing has happened around the country, and it happened here to a degree in Oklahoma. I served with two really good Oklahomans in Don Nickles and David Boren. I served on the Finance Committee with Dave, and worked with Don in Labor and Human Resources. And these are the two committees that deal with Federal policy in health care. So, in this State, I think it is

the only, probably the only State in the country in which, at least the only one that comes to mind, in which your two Senators served the health care interests from the standpoint of two very, very important committees.

But I want to start right there at the end of your comment with the children and grandchildren.

As you know, we just finished a session which we accumulated another $380 billion in Federal debt. It is going to cost our children and grandchildren $28 to pay off every one of those $380 billion. And it is not something that Don Nickles visited on you, or Dave Durenberger visited on the people of Minnesota. We are all in this debt ballgame together. And if we do not start caring about our children and our grandchildren in some sense, one of these days we are all going to be in trouble. Read the Wall Street Journal this morning and find out the wonderful new inventions that we have to avoid them. A little itty-bitty article on something called zero coupon bonds. Freddie Mac is doing what Fannie Mae was doing a couple of weeks ago, that is the housing, the Federal subsidized backup to the housing system. And they are going to use something called zero coupon bonds, go out and sell $7 billion worth of current debt, and no interest payments on that date until the year 2019. About the time that my kids will be getting ready to celebrate their 55th birthday they will be loaded with seven times $31 billion in debt so that I can have housing today, or we can have housing today.

Those kids, or kids now, will be paying that in the year 2019.

And that is the environment for all of us, reminds us of what Thomas Jefferson tried to tell all of us in politics in many, many years ago. That is that there is a moral imperative that we leave the next generation at least, at least as well off as we are. He did not even say better off like we all want to do. He just said leave them as well off at least as we are.

And as someone who comes to this State from the outside, let me just say as a society we are not doing a very good job in leaving the next generation as well off as we.

Now, the health care area is one area, as Don indicated, the quality is the best in the world. Well, yes, maybe it is. Maybe it is. It is also the most expensive in the world, about three times as much per capita is spent in this country as anywhere in the world. Then why is it that 50 percent of the deaths occur from heart disease compared to like 5 percent at the turn of the century? Why is that? Why is that that we rank 17th in the world infant mortality? If we spend three times as much as anybody else, if we are so proud of all these new inventions that come out of our system, why is it that we are 17th in infant mortality? It has a lot to do with our attitude toward health care as a right. And as we all go through the process of looking to the future, we can spend a little time looking to the past and how we in effect have said somebody owes it to us. The employer owes it to us. The Government owes it to us. Blue Cross owes it to us. The docs owe it to us. The hospitals owe it to us. All that sort of thing. And we do not owe anything. You know, we do not have to quit smoking. We do not have to quit drinking. We do not have to wear helmets on motorcycles. We do

not have to do any of those things. Somebody else is going to take care of those problems for us.

And that is to a degree where we are at today. I do not think there is a person in this room that can deny that that sort of is not the way we worked ourselves up in the system, and we are all very uncomfortable with it.

The one thing you ought to try to prevent is that politicians like us try to reverse this whole system. Do not let the Government start deciding who lives and who dies because we are not at the stage yet where, and I hope we will never be at this stage, where we have to make those kinds of decisions. There is so much inefficiency in the way we use those 360 billion a year. We do not put it into maternal and child health. We put it into $4,000 a day neonatal intensive care beds. That is what we do in this society.

And there it is. And I talked about our life style already. There is a lot of inefficiencies in this great American health care system. And the reason Don and I do what we are doing here this morning is because there is no way we should be passing a great new piece of legislation to undo American lifestyles and smoke out all these inefficiencies and so forth. We are here because at this particular point in time the Government as such, Federal, State and local, have to play a role to facilitate the decisions that you want to make about wiser use of those health care dollars. And I guess, as I look at the hearing list, we have got, starting with somebody from the world's largest, Nation's largest accounting firm, I mean somebody who has looked at the people's opinion on these subjects and what we ought to do. And then we are going to go through a wide variety of other experts to share with us what it is we ought to be doing differently. And maybe somewhere along the line we will hear somebody say do not do anything differently, just spend more money on it. If that is true, here in Oklahoma, I will be surprised. I will really be surprised. And one of the things I have noticed since I have been here is that this State is in the process of doing something about health care for the indigent explicitly. The State is trying to say we have a problem, and rather than trying to hide those problems in our hospital system where nobody can see them except the poor hospital administrator, let us deal with it explicitly.

Yes, we do have media among us, and let us take our sales taxes and deal with that problem. I want to say to you I have not seen that anywhere in the United States of America except in Oklahoma. Everywhere else they are trying to hide that problem and stick it in the hospital where nobody can see it, and pretend hospitals can be more efficient when they have to educate doctors that people say we do not need, or they have to take care of the poor because you do not have public hospitals. Oklahoma is dealing with it, and I am proud to be here today.

Senator NICKLES. Senator, we are proud that you are here. One of the reasons why we have a hearing in the field is to get some input from people. A lot of time, all Washington hears is Washington, D.C, rather than really getting the grassroot sentiments, ideas, and some problems that are confronting us, along with some of the solutions. We have an outstanding list of panelists today coming from all sectors of the health care industry.

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Our first panelist, Charles Bradford, is the international health care director for Arthur Andersen. Their firm has just recently released a study which is stirring a lot of discussion in all parts of the industry, talking about what is going to happen in the 1990's.

Mr. Bradford, we welcome you, and we appreciate your attendance. We have 15 panelists, and so that people will understand the format a little bit better, we hope to conclude this hearing by 12 o'clock. It will be necessary for all of our panelists to keep their remarks brief. And we will keep our questions brief so we can get to all our panelists.

Mr. Bradford.

STATEMENT OF CHARLES BRADFORD, INTERNATIONAL HEALTH CARE DIRECTOR, ARTHUR ANDERSEN & CO., CHICAGO, IL, ACCOMPANIED BY DON YESUKAITIS, NATIONAL HEALTH CARE DIRECTOR, ARTHUR ANDERSEN & CO., WASHINGTON, DC

Mr. BRADFORD. Thank you.

As you indicated, I am Charles Bradford, partner of Arthur Andersen. And not talking light, I am currently serving as our firm's health care director. And I am most pleased to have the opportunity to appear before you today.

Our firm and our cosponsors, the American College of Hospital Administrators, conducted a study entitled "Health Care in the 1990's" during 1984 to determine if there was a consensus among 1,000 health care experts who responded to our survey on the future direction of the industry. We felt that it was appropriate to perform such a study because, among other reasons, the party trust fund has predicted to face bankruptcy in the 1990's, and because of the changes in the health care delivery system fostered by the Federal prospective payment system and other State initiatives to contain health care costs.

The study has been made a part of the record, and I would like to spend a few minutes highlighting its findings. I should note that the findings are not mine or the firm or the American College, but those of the experts who responded. So please do not kill the messenger.

The health care of the study predicted it will continue to be a growth industry. By 1990, health care expenditures will capture 12 percent of our gross national product versus 10½ percent today. By 1995, Medicare's total expenditures for the total health care expenditures will grow by an additional 20 percent, and that the Government will continue to be the largest purchaser of health care. Hospital expenditures will shift by 1995 in their share of the total health care expenditures toward more ambulatory care with the most significant shift appearing in nursing home expenditures which will increase from 9 percent of the health care expenditures to 13 percent. Hospital admissions will drop some 5 percent, and length of stay will decrease 1 day to 6.5, or about 15 percent with the combined drop in use of hospital beds of some 20 percent.

As a result, hospitals will begin to expand in alternative delivery systems and provide greater outpatient care, doubling from their present level to 25 percent of their business by 1995.

Multihospital systems, both investor owned and not for profit, will grow significantly by 1995. And by that time, they will own, manage or control 53 percent of nongovernmental hospital versus 36 percent today.

Two key issues addressed in this study were access to care and quality of care. The panelists predicted that there will be a change, that HMO enrollees and private pay patients will have higher quality of care and greater access. That no change will take place for those insured by Blue Cross and other commercial carriers, but that there will be a decline in both quality and access to the indigent and Medicare-Medicaid beneficiaries. Several Medicare changes are anticipated by the panelists. They believe that Medicare should limit expenditures for extending the life of the chronically ill aged, and that Congress will define life and death.

Our experts do not expect national health insurance or State systems to replace the Medicare system. They do predict, however, that Medicare will further limit by the 1990's inpatient hospital coverage and coverage for physicians' services. But they also believe that Medicare will extend coverage to outpatient care and for skilled nursing, home health, and hospice services. They also expect Medicare to implement a means test by 1990, advance the eligibility age, provide catastrophic coverage, increase significantly beneficiary deductible insurance and premiums, implement a voucher system, and require physicians to accept assignments.

I am just the messenger.

Other changes or findings of the survey were the Federal or State government will limit the amount of malpractice awards; that the favorable tax treatment of employer paid health insurance premiums will be reduced or eliminated. Medical research and teaching will continue, but that payment should not come from patient care revenues. And that cost shifting will continue to be a tax.

With respect to the prospective payment system, our panelists believe that the following services will come under the PPS methodology by 1990:

Physicians' fees, skilled nursing care, home health, psychiatric and substance abuse, and hospital capital costs. The hospital CEO's were specifically, had some major concerns. And they are the continued financial viability of their institutions, access to capital, and declining census. They believe that the key to financial access is in productivity. Our experts also believe that the Federal Government will still provide the largest source of hospital revenue by 1995, but anticipate they decline from commercial insurance in a fivefold increase to 10 percent from HMO's, PPO's and life plans.

In terms of containing health care costs, the three top suggestions of the panelists were emphasize alternative delivery systems, make that the foretop, delivery system ambulatory care, increase patient cost sharing, implement a different payment system such as capitation, vouchers, all pay for DRG system.

And, fourth, educate public on wellness and preventitive medicine.

The study is part of the record. In closing, it is obvious that the study indicates tremendous changes in our health care delivery system in the next 5 to 10 years, changes which will affect all of us.

Thank you.

Senator NICKLES. Thank you very much, Mr. Bradford.

A couple of questions.

This is a very extensive study. Is this the summary of the study?

Mr. BRADFORD. That is correct.

Senator NICKLES. Probably there is a lot of people who would be interested in this.

How can one get a copy if they were not fortunate enough to pick one up?

Mr. BRADFORD. I did not come here to sell the study, but the studies are available through our firm, or through the American College of Hospital Administrators. They could contact our local office or through the ACHA.

Senator NICKLES. We could spend the entire 2 hours on your study and the results because you touched on a lot of issues.

How did you compile this study? Through a survey of 1,000 health experts?

Mr. BRADFORD. I think that is a good point. People have asked us the probability of these predictions taking place. Recognize that the survey was of people who are either providers, purchasers, legislators, suppliers of health care, these are what would be referred to as the movers and shakers of the industry. So that it has been our perspective that since these people believe that this is the direction that health care is going, that they will expend their resources and their energies in anticipation of these predictions, and that therefore in many respects the predictions may be self-fulfilling.

Senator NICKLES. Senator Durenberger, did you have any comments or questions?

Senator DURENBERGER. First an observation. I apologize for being so dumb I did not turn this thing on before. But if it is a self-fulfilling prophecy, I would venture to say that a lot of what is in here will, in effect, happen because I have looked over it. But the interesting thing is that if you had taken the same survey 3 years ago, I do not think any of this would have shown up, maybe a little bit would have shown up, but not in the kind of detail that you find here.

One of the areas I am interested in, maybe it is just a matter of the way it is interpreted, when you talk about what was that conclusion, the four top suggestions, one of them is alternative delivery systems. Another is patient cost sharing. The third is implementation of different payment systems as they are called, capitation vouchers, or all payer prospectives, so forth, I do not see in there a choice of health plans. I do not see any of this, looking at it from the standpoint of the consumer and saying that one of the things that is going to be needed to make this whole system work is to give people a choice of health plans.

Was that issue examined in any detail?

Mr. BRADFORD. Perhaps not specifically. However, there is evidence that with respect to PPO's and HMO's that there will be a tremendous growth, fivefold growth. And in fact I think that may be an understatement because we are seeing so many insurance companies shifting to these types of payment plans. The other aspect is there is a great deal of discussion that the consumer will have much greater involvement both in the payment for their

health care services, and therefore they address that the hospitals will have to be addressing the patient as a market. And that they expect the patient to be much more a prudent buyer so that the prudent buyer aspect is addressed to some extent in the survey.

Senator DURENBERGER. The last question deals with cost shifting as it is addressed in the report.

There are two ways to look at cost shifting. The report, as I glanced through it, seems to treat cost shifting as taking money from Blue Cross or the commercial insurers, and using it within the hospital system to cover the cost of sharing care, or in fact that Medicare is cutting back.

So you use it in that area, and there seems to be a prediction that State of federally mandated all payers systems will stop this cost shifting. That if we could just make everybody pay the same thing for a liver transplant, or an appendectomy, or pneumonia, make sure Blue Cross pays the same thing that Medicare and commercial insurers pay the same thing, then we would take care of the problems of cost shifting.

The second way to look at it, of course, is at different hospitals they are asked to do different things. Some hospitals are asked to take a heavy load for teaching. And they are the only place they can give the money to, that is out of patients. They have to have some sick people come to the hospital or they could not afford to do all that teaching. Some hospitals, particularly those that are close to the inner cities of our larger cities, have an especially large indigent health care group. So there has been a traditional cost shifting between people that pay and people that do not pay in our society. I have never felt that in all payer systems that solved that problem. Just saying that Blue Cross and all the third-party payers are going to raise their fees so we can take care of the indigent or take care of educating doctors is not going to satisfy a lot of consumers who think we have too many doctors, and there ought to be other ways to take care of the poor.

How do your experts come to grip with this issue?

Mr. BRADFORD. Very good question, and not that the other one was not.

Senator DURENBERGER. You mean my first one?

Mr. BRADFORD. It looks like we may have skirted the issue to some extent, although they talked about teaching, and that the patients should not be responsible for paying for the teaching and research. And that they talk about getting funds from another source such as foundations or perhaps separate Government grants. May be a little Pollyannish.

I think you hit a major concern that may not jump out at everybody in the study. But that if everybody pays the same, then the teaching institutions are going to suffer for just some of the reasons you have mentioned; that teaching programs do cost more. And that I think the Congress should be very sensitive about continuing the other prospective payment system, the teaching institution supplement, either the direct teaching or indirect teaching.

I think the other aspect of it that has not been implemented in the prospective payment system is the health care finance administrations totally ignoring the need to have a special consideration for hospitals that do provide a lot of the services to Medicare and

Medicaid patients, particularly the inner cities. I am not trying to avoid your answer because the survey has to speak for itself. But you have hit a major concern, and if you were to tie just two or three of the exhibits together, the fact that they talk about the governmental institution having to take more charity patients, and yet there will be a drop in the number of governmental institutions, and that, third, governmental institutions are to provide a lowest level of quality.

Senator DURENBERGER. Thank you.

Senator NICKLES. Thank you very much.

Our next panelist is William Horkey. He is vice president of Helmerich & Payne, and in that capacity has taken a leadership role in the Tulsa business community, A business health care group which has the participation of major employers in the area. Together they have pooled their clout and have worked to see if we cannot make improvements to indigent care in the Tulsa area.

STATEMENTS OF WILLIAM R. HORKEY, EXECUTIVE VICE PRESIDENT, HELMERICH & PAYNE, AND CHAIRMAN OF THE TULSA BUSINESS HEALTH GROUP, INC., TULSA, OK; GEORGE PROTHRO, M.D., PAST PRESIDENT OF THE TULSA COALITION FOR OLDER PEOPLE, TULSA, OK; AND UDELL LaVICTOIRE, COORDINATOR, HEALTH ADVOCACY SERVICES, AARP, OKLAHOMA CITY, OK

Mr. HORKEY. Senator——

Senator NICKLES. You might talk right into that microphone.

Mr. HORKEY. I will respond directly to the paper prepared for you by the Library of Congress, and to make a local joke, my presentation may sound more like Linda Soundtrack than Dick Horkey, due to the time constraints.

Addressing the history of Federal initiatives for health care reform, I categorically reject price controls as embodied in the Economic Stabilization Program. Price controls are palliative, doing nothing to correct the underlying causes, and for the most part aggravating the problem and causing greater economic distortion and dislocation upon removal. I speak with strong emotion and from unpleasant experience relating this to the Federal Government's ill-fated and abortive attempts to regulate the price of natural gas.

Senator DURENBERGER. We hear you.

Mr. HORKEY. I strongly support the concept of local health planning and allocation of capital resources, but favor encouraging these outcomes on a voluntary basis prior to invoking mandatory certificates of need. I support the concept of PSRO's and PRO's as self-governing professional self regulation to address necessity and reasonableness of care, quality of care, and appropriateness of the setting in which services are rendered. I support prospective payment systems as an alternative to and needed reform of the fee for service cost reimbursement system.

I believe the DRG's with refinement will introduce competitiveness into health care delivery and thereby facilitate cost containment. I categorically reject the DRG system as camouflage toward price controls. Competitive factors should determine pricing for DRG's.

With regard to current proposals for health care reform and beneficiary/patient related proposals, I am a firm believer in the efficacy of cost sharing for Medicare, Medicaid, and private pay patients. I believe the Rand study and empirical evidence demonstrates that the person who has personal financial involvement in the purchase of health care services buys less unnecessary health care without appreciable differences in the quality of the care and of personal well being. I believe that to the extent cost sharing under Medicare works financial hardship on individuals, a solution can be arrived at by integrating service for these individuals through the Medicaid Program. I believe that the categorical qualifications for Medicaid must be reduced to a simple financial qualification.

I do not support partial payment to providers for services rendered. This perforce gives rise to cost shifting and effects hidden taxation to paying patients. The Government should either purchase the service at a fair price or not purchase it at all.

Senator NICKLES. I am going to ask the audience not to have shows of support for statements and whatnot because you are going to hear a lot of things you are going to agree with, and a lot of things you are not going to agree with. We have got a variety of panelists coming from different viewpoints. And I think it would be more respectful if we would just hold our applause so we can let our panelists make their cases.

Please proceed

Mr. HORKEY. I support proposals for voucher payments for Medicare or Medicaid patients as being a further departure from the fee-for-service cost reimbursement system which has proven to be an economic disaster, and voucher payments to be a stimulant for alternative health care delivery systems by prospective payment to at-risk providers which will stimulate competition among providers leading to further cost containment.

With regard to hospital related proposals, I firmly believe that competitive factors are a more reliable means of controlling increases in prospective payment rates than is Government fiat. Again I believe that self-regulation through PRO's and competition will be the best protection against abuse of the system.

I believe any system requires continuing monitoring and vigilance. I have unlimited faith in the ingenuity of man to eventually beat any system man devises. Cost reimbursement, that is, cost plus, was an expedient method for providing quality health care to the masses. That system has been abused. We can no longer afford it. Prospective payment systems will reverse the directions of cost reimbursement. In time, we will have to devise something to overcome the abuses that will arise in prospective payment systems. In the interim, prospective payment systems are the best game in town.

I oppose State-mandated all payer systems as being undisguised price freezing. Instead, I advocate legislative encouragement of public advertising of provider pricing, and the waiver of antitrust provisions which would inhibit price information exchange by employers and cooperative buying mechanisms to place individuals and small employers on an equal purchasing power footing with large purchaser groups.

With respect to the physician-related proposals, I would initially support a DRG-determined price for physician services, but would favor competitive factors for setting such prices as opposed to the long-term ridiculousness of precluding a physician or any other seller of merchandise or service from reflecting increases in prices by reason of increases in costs to provide the product or service. I believe that the PRO's are the preferable way to prevent physicians from abusing the system by unjustifiably increasing the volume of services merely to achieve a desired level of income. I have faith in the integrity of physicians as a professional whole and in their adherence to their Hippocratic oath.

I strongly urge the encouragement of prospective payment systems for integrating inpatient/outpatient services rendered under the concept of a primary care physician as a case manager responsible for the well-being of an individual and, better yet, a family on a continuing basis as opposed to purchasing services on an isolated event, episodic process.

I do believe that medical malpractice is an urgent concern of everyone. I believe we have become a litigious society bent on arbitrarily compensating injured persons on the deep pocket theory with little regard to fault and equity. I therefore support a no-fault medical practice plan, excepting therefrom gross negligence and wanton disregard.

With regard to employer/employee-related proposals, I categorically reject tax caps. This is merely another form of price fixing. The latest Government statistics indicate that for 1983 health care consumed 10.8 percent of gross national product. Employers are painfully aware of the increasing share of payroll dollars going to health care benefits. Payroll taxes for social security, Medicare, and unemployment insurance are escalating. Workmen's compensation premiums are escalating. Competitive factors will require employers to limit the payroll dollars available for fringe benefits and utilization of cafeteria plans will force employees to elect from the various benefits available. Health benefits are a middle-class benefit. Over 80 percent of those with health care insurance earned less than $25,000 in 1983. Seventy-five percent of the tax value goes to those earning less than $50,000 a year. Employers in the Tulsa area are already well along toward restructuring health benefits, encouraging informed purchasing of health services, encouraging preadmission testing, second surgical opinions, and ambulatory surgery. HMO's and PPO's are an established competitive factor in Tulsa and employers are promoting them as a viable alternative for procuring medical services and as a cost containment measure.

I believe self-insurance is a viable alternative, and that concern need be had only with regard to establishing reinsurance for catastrophic losses for employers not meeting certain financial standards. I also believe that whether on a State or Federal basis it is advisable to require all employers to provide some minimum standard of health care benefits for their employees.

Thank you for the opportunity to make this statement.

[The prepared statement of Mr. Horkey follows:]

Statement to Senators David Durenberger of Minnesota
and Don Nickles of Oklahoma
for hearing on
"Reforming our Nation's Health Care System"
October 15, 1984, Tulsa, Oklahoma

My name is W. R. Horkey. I am Executive Vice President of Helmerich & Payne, Inc., a 65-year old publicly held private enterprise corporation engaged in the production of oil and gas, the drilling contracting business, and other enterprises.

I am President of both Tulsa Business Health Group, Inc. and Tulsa Community Foundation for Indigent Health Care, Inc; Chairman of both Emergency Medical Services Authority and the Tulsa Business/Medicine Hospital Coalition; Treasurer and a Director of Oklahoma Chapter of American Red Cross; Trustee of Tulsa Medical Education Foundation; member of Medical Advisory Committee for Indigent Health Care, Oklahoma Department of Human Services; and Director North Tulsa Ambulatory Health Care, Inc.

I am responding to Health Care Reform Options paper of October 5, 1984, prepared by Janet Lundy/Anne Stewart, Health Analysts, Congressional Research Service, Library of Congress.

Addressing the history of Federal Initiatives for Health Care Reform, I categorically reject price controls as embodied in the Economic Stabilization Program. Price controls are a palliative, doing nothing to correct the underlying causes and, for the most part, aggravating the problem and causing greater economic distortion and dislocation upon removal. I speak with strong emotion and from unpleasant experience relating this to the Federal Government's ill-fated and abortive attempts to regulate the price of natural gas.

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I strongly support the concept of local health planning and allocation of capital resources, but favor encouraging these outcomes on a voluntary basis prior to invoking mandatory Certificates of Need. I support the concept of PSRO's and PRO's as self-governing professional self-regulation to address necessity and reasonableness of care, quality of care, and appropriateness of the setting in which services are rendered. I support prospective payment systems as an alternative to and needed reform of the fee-for-service cost reimbursement system. I believe DRG's with refinement will introduce competitiveness into health care delivery and thereby facilitate cost containment. I categorically reject the DRG system as camouflage toward price controls. Competitive factors should determine pricing for DRG's.

With regard to Current Proposals for Health Care Reform and Beneficiary/Patient Related Proposals, I am a firm believer in the efficacy of cost sharing for Medicare, Medicaid, and private pay patients. I believe the Rand study and empirical evidence demonstrates that the person who has personal financial involvement in the purchase of health care services buys less unnecessary health care without appreciable differences in the quality of the care and of personal well-being. I believe that to the extent cost sharing under Medicare works financial hardship on individuals, a solution can be arrived at by integrating service for these individuals through the Medicaid program. I believe that the categorical qualifications for Medicaid must be reduced to a simple financial qualification.

I do not support partial payment to providers for services rendered. This perforce gives rise to cost shifting and effects hidden taxation to paying patients. The Government should either purchase the service at a fair price or not purchase it at all.

I support proposals for voucher payments for Medicare or Medicaid patients as being a further departure from the fee-for-service cost reimbursement system which has proven to be an economic disaster and to be a stimulant for alternative health care delivery systems by prospective payment to at-risk providers which will stimulate competition among providers leading to further cost containment.

With regard to Hospital-Related Proposals, I firmly believe that competitive factors are a more reliable means of controlling increases in prospective payment rates than is Government fiat. Again, I believe that self-regulation through PRO's and competition will be the best protection against abuse of the system.

I believe any system requires continuing monitoring and vigilance. I have unlimited faith in the ingenuity of man to eventually beat any system man devises. Cost reimbursement -- i.e. cost plus -- was an expedient method for providing quality health care to the masses. That system has been abused. We can no longer afford it. Prospective payment systems will reverse the directions of cost reimbursement. In time, we will have to devise something to overcome the abuses that will arise in prospective payment systems. In the interim, prospective payment systems are the best game in town.

I oppose state mandated all payer systems as being undisguised price freezing. Instead, I advocate legislative encouragement of public advertising of provider pricing and the waiver of anti-trust provisions which would inhibit price information exchange by employers and cooperative buying mechanisms to place individuals and small employers on an equal purchasing power footing with large purchaser groups.

With respect to Physician-Related Proposals, I would initially support a DRG determined price for physician services, but would favor competitive factors for setting such prices as opposed to the long-term ridiculousness of precluding a physician or any other seller of merchandise or service from reflecting increases in prices by reason of increases in costs to provide the product or service. I believe that PRO's are the preferable way to prevent physicians from abusing the system by unjustifiably increasing the volume of services merely to achieve a desired level of income. I have faith in the integrity of physicians as a professional whole and in their adherance to their hypocratic oath.

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arbitrarily compensating injured persons on the deep pocket theory with little regard to fault and equity. I therefore support a no-fault medical practice plan, excepting therefrom gross negligence and wanton disregard.

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I believe self-insurance is a viable alternative and that conern need be had only with regard to establishing re-insurance for catastrophic losses for employers not meeting certain financial standards. I also believe that, whether on a state or federal basis, it is advisable to require all employers to provide some minimum standard of health care benefits for their employees.

Thank you for the opportunity to make this statement.

Senator NICKLES. Thank you very much for your statement. It is a very comprehensive one. And, again, as a person who is working in the private sector, I compliment you for the amount of energy, effort, and time that you have spent in analyzing the problems and solutions that you have recommended.

Senator DURENBERGER. Now that you have looked at your clock, I am going to have to be very brief.

Let me say this. Excellent is the best word I can find for the statement, not just because I agree with practically everything in it, but the way in which you articulated it. I think it is very meaningful.

You take that and compare it with what businesses are doing in other parts of the country where they are trying to push for the price control. I cannot understand it. Why are they doing it? The only—you said at the end that you opposed the tax cap.

Mr. HORKEY. Yes.

Senator DURENBERGER. And you say it is a middle-class benefit.

I would just make the observation that, yes, it is a middle-class benefit. But the middle class cuts very differently. We are in effect, taxpayers are paying about $30 billion a year now for that benefit. But they pay it rather unevenly. United Auto Workers, if you are an auto worker in Detroit or somewhere here, Chrysler for example is $6,000 paid by some taxpayers so they can have a very rich health benefit. But you go out in some small businesses in this State, the small farmers, ranchers and so forth, they are not getting that, the same benefit. Yes, they could if they could afford the premium, but a lot of them cannot pay the premiums. And one of the reasons we are trying to deal with the motion of the tax cap, while it is of benefit, it is very, very unevenly distributed. If a highly unionized old line company are getting a lot more taxpayers' dollars going into this than are a lot of little people.

But the part I do agree with, and maybe the direction we should be going, if we are going to give that kind of benefit to the employer/employee relationship, maybe we should condition it in some way. In other words, we have this big human cry the last couple of years about health care for the unemployed. And we almost had a whole new program for people who could have been covered for 6 months or even up to a year of temporary unemployment by their employers' health insurance.

Is that the kind of thing you are saying we have to consider, be part of the employment relationship?

Mr. HORKEY. Yes, sir.

Senator, the New York Business Health Group did a very interesting study. And it is amazing the number of people, and the numbers of self-employed people in the country who work for small businesses, and the almost total absence of health care provisions for those employees which then goes in an extremely large number of people who become medically indigent. So it is to broaden the participation in this benefit.

On the other side, on the old line industries like Chrysler, for instance, the labor unions are now acknowledging that the costs are out of control. And they realize they are going to lose this benefit unless they effect some of the reforms in the manner in which

these services are delivered, and in some employees' participating purchasing those services.

Senator NICKLES. Mr. Horkey, thank you very much for your statements.

I am going to advise all of our panelists that their entire statement will be made a part of the record. So it will not be necessary to read their comments.

And, again, we are going to have to expedite the hearing a little bit.

Our next panelist is Dr. George Prothro who is past president of the Tulsa Coalition for Older People.

Dr. PROTHRO. Senator Nickles, Senator Durenberger, I am on the panel as a consumer as my role as a member and past president of the Tulsa Coalition for Older People. I cannot divorce myself from the fact that I am also a physician, have had a career in private practice in public health, and in medical education. I am sure that neither group will think that I am speaking for them at the conclusion of my remarks.

Let me first address the Medicare Program. I think that we are all concerned with the extreme cost, increasing cost of the Medicare Program, escalating cost of the program. We are concerned about the increasing cost of the Medicare Program to the Government which means to all of us and, yet, at the same time from the standpoint of the consumer, we are concerned about the fact that the Medicare Program is meeting less and less of our overall health care costs, and is taking more and more out of our pockets. This is in fact due to the increasing deductible, but probably more to the fact that many of the consumers find physicians reluctant or unable or unwilling to accept Medicare assignments. And perhaps this has been the biggest burden on the Medicare patient.

Sometimes I think that this boils down to a problem of communication because when I meet with physician groups, they generally always say, and I believe sincerely, that I am willing to accept Medicare assignment on a patient who really needs it, the patient who has a hardship. But I am not willing to adopt a policy of accepting Medicare assignment on all patients because I think many of the patients are able to pay my full charges.

So if they will talk to me about it, I will do this on an individual basis.

I talked with consumers and, of course, basically we are all consumers. They say, yes, this is fine. The problem is how do I get through to talk to the physician? I am met by the girl at the front who says our policy is we do not accept Medicare assignment. So I never get through to talk to the physician. Plus the fact I think there is a reluctance on the part of patients to tell their physician they are having an income problem. They feel somehow or another this may be a little demeaning, may compromise their health care if a physician thinks he is not going to be paid completely. That maybe he will cut down on some of the services that they need.

I do not think this is true but, nevertheless, this is a feeling unfortunately. We cannot legislate communication.

Now, what is needed for the patient on Medicare? First of all, I think there is a whole spectrum of needs, and the needs of all patients on Medicare are not the same, and perhaps this is one of the

things that we should address, and perhaps one of our problem areas now.

The low-income patient needs basic coverage of all of their health needs by their program. On the other hand, there are those at the upper end of the financial spectrum whose main concern is probably catastrophic coverage. And they are able to bear and willing to bear the cost of ordinary health care, but they get into real concern about some of the catastrophic problems that major health care costs.

So I feel that Medicare is going to have to implement a means test for Medicare with the coverage provided under Medicare. And this relates to the deductible and the coinsurance to be based on the income of the recipient. And this again would be probably two levels, or perhaps even two different types of Medicare for those at the lower income, something basically on the basis of the present plan with perhaps even a reduction of the deductible and coinsurance for some of the very low income, again on a sliding basis for some of those that are above that, to a type of policy at the other end which would provide catastrophic coverage for those who are at a higher income level. And catastrophic coverage could also be based on income because catastrophy is not the same to a person with an income of 50,000 versus a person with an income of a quarter of a million.

Now, to comment on the DRG program and the reimbursement mechanism, I commend Congress on this approach. I am sure that over a period of time that it is going to have to be modified as does anything new, but I think it is a most worthwhile approach in doing something to contain cost. I feel that we are going to have to extend the DRG basis to the physician under part B, and again if we had the type of a program that I mentioned before where those people who are on the low income had the complete Medicare coverage, I think in that case that we should mandate Medicare assignment to physicians for those people who are on low income. And this would also mandate acceptance of the DRG basis of reimbursement.

One of the things that Medicare, as well as other Federal programs, need to look at is to encourage coverage to additional home health care services. I think an outstanding example there is the fact that many older people are institutionalized now in nursing homes when they could remain at home with maybe only the provision of home health services. And yet, under the present Medicare Program, a person is not eligible for home health services unless they also require skilled nursing services. I know again there are many people out there who could be maintained in their home if they could have some of these lesser services, and they actually do not need the skilled services.

I feel that there should be some pilot studies to determine the cost effectiveness of covering certain specified preventive services. I think that we should encourage preventive services. I was interested in studying the Danish health system a few years ago. Just for one example, that dental care is provided. However, when you go in to have your tooth filled or your tooth pulled, if you have been in for your preventative checkup as provided under the system,

then you do not have to pay anything. If you have missed your appointment for preventative checkup, then the burden is on you.

So again, an incentive to preventive services. I think there are many examples of how we can work this in to this system. You know the old saying, "An ounce of prevention is worth a pound of cure."

Medicaid I think some of the same approaches, I think at the Federal level, there should be efforts to enable and encourage States, and much of this has already been done, cover more home services, to vary coverage to provide different levels of institutional services, and also to implement plans similar to the DRG system of prospective payment.

A couple of other comments. No. 1, in line with what Mr. Horkey said, I think the importance of evaluation of any new program that we undertake has to be taken into consideration. Evaluation of both quality and cost incurred.

As he mentioned, any time a new system is put into place, then the reaction, well, how do we work this system? And this is national reaction. For example, under the DRG system, hospitals are faced with the burden how do we work the system to get the most out of it? As a result, we are creating a new type of health professional, a type of health professional that can juggle the diagnoses to come up with the best reimbursement mechanism. We are coming up with hospitals, and again I would do the same thing in their position, are creating their own home health agencies, which is fine except it is causing a duplication of home health agencies and, thus, in the long run, an increase in cost.

So when we evaluate these systems, we not only need to reevaluate the actual cost that we reimburse hospitals under the DRG less than going under the previous system, but what about have there been increased costs, administration, and monitoring, both at the Federal and the State and local level? We need to evaluate the total costs.

Senator NICKLES. Could I interrupt you here?

Again I am going to have to ask all of our panelists to keep their remarks short so we can get to the balance.

Could I ask you a question at this point?

One of the major changes that you called for was a means test on Medicare. You are in the health profession, how do you think that that would be received amongst the constituency of people in the age group 60 and above?

Mr. PROTHRO. The means test?

Senator NICKLES. Yes.

Mr. PROTHRO. Well, I think that any time that you take something away from people that they have had in the past that there is going to be discontent and dissatisfaction. Nevertheless, I feel that personally this type of approach is essential. And I think that if it was based on a fair method related to the income, I believe that would be acceptable rather than the alternative of the road that we are going down now

Senator NICKLES. You also called for including physicians into the DRG system and for mandatory assignment, is that right?

Mr. PROTHRO. Yes.

Senator NICKLES. We are going to have a physician panel in a moment. I expect they would have some disagreement with that position.

Mr. PROTHRO. This again, the mandatory assignment for these who are on the low income Medicare Program, I think again there has to be basically two types of Medicare Program. One for the higher income, one for the lower income. I think just for those who are on low income, and I think the physician should be able to identify from the type of program they come with with their card or whatever, that this person is eligible for assignment.

Senator NICKLES. Senator.

Senator DURENBERGER. Don, I wonder if I might make an observation.

Just looking at my watch, I do not know whether I am on Minnesota time or what, but we do have 11 people left to go. And I do not know whether you are trying hard to be the tough guy in this thing, and maybe I ought to be the one to say to everybody you really got to keep it to 7 minutes. The reason I am here is the record of this hearing and your statements in full, I want to make part of the 1984 series of hearings that we are having on Medicare and on related programs like Medicaid and the long-term care issues, and on graduate medical education and some of these.

So what you have to say in a more elaborate form, even though you do not get to say it in 7 minutes, will be made a part of the record of the 1984 hearings.

Mr. PROTHRO. I am through except for one sentence, that the malpractice has to be addressed, something done to increase arbitration, limit awards under malpractice.

Senator NICKLES. Thank you.

Our next panelist we have is Udell LaVictoire, the State health advocacy coordinator for the AARP.

Mr. LAVICTOIRE. Senator Nickles, I believe we owe you a compliment for recognizing the health costs as a serious problem it is and organizing this hearing. I think you will have some others throughout the State.

Senator Durenberger, I will not attempt to evaluate your questions.

Somehow I have a feeling that I am in a minority here. You have outlined in your paper very well the fact that we are now in a critical period. And by 1990 or 1989 or 1991, whichever formula you take, we will be in a crisis, a very severe crisis. Medicare will be broke by then. And that means that older people who are now paying as much as they ever paid out of pocket for health care will be paying considerably more. But when we talk about considerably more, let me tell you what it looks like from the individual's point of view.

Health costs, both hospitals and physicians, have been skyrocketing up for the last several years. Hospital costs particularly; 18 percent a year on an average for the Nation, 23 percent a year for Oklahoma. Now, 23 percent a year means that the cost doubled every 4 years, a little less than 4 years.

Now, during the past several months, I have spoken to groups, the total number were perhaps about 800 or 900 older people. And we have placed this, our association, we have 17 million members

throughout the Nation, 140,000 in Oklahoma. We have placed this as our top priority out of the continued expressed concern on the part of our people. Concern which is bordering with some on almost panic.

In these groups, approximately 60 percent of the group had used hospitals, or their immediate family during the past 2 or 3 years. Out of that group, in every group I spoke to, there was at least one person who had a $50,000 bill; $10,000 bills were common. Well, now, conceive of what $50,000 will mean in 1990 at the same rate of increase, $200,000. $10,000 bills will mean $40,000. If the same rate continues.

Now, obviously, there are not many people, particularly in the older group, whose immediate income is less than half that of the younger population can afford to pay this kind of a cost. We unfortunately in Oklahoma also have a very low rate of acceptance by physicians of Medicare assignment, one of the lowest in the Nation, which is unfortunate. We believe that we will have to come to some form for the immediate crisis, for some form of control until a better system can be worked out for all payers. We are as concerned about the total population as we were about the older people. We believe, and I am glad to say that in your comments, Senator, you indicated that it was the cost of care that was the prime problem, the cost to the Government important, but unless you solve the first, you cannot solve the second So that needs the concentration.

We propose for the immediate a combination of Federal and State regulatory bodies. Six States have already done that, and have had this type of control in for over 10 years. They have kept their cost to a 10-percent annual increase. We believe an annual increase related to inflation with a few extra percentages for new technology would be accurate. But we see no other solutions for the immediate.

For the long-range future—I see you are shaking your head—no, Senator Durenberger. I knew we would disagree on that.

For the long-range future, we are organizing workshops and seminars for older people on the stay well concept. On many of the aspects, we are promoting the concept of competition. But we do not have competition now. And I do not see it to any appreciable degree within the next 4 or 5 years.

We have one health—we have one large health maintenance organization in the Oklahoma City area. It has 26,000 members of which 25 are older people. We are bad risks. So that until, and I want to harken back to your statement at the end, Senator Nickles, where you say it is not enough to just keep fueling the machine by raising taxes. True reforms are necessary.

And I would like to comment on a few of the—one question about the reaction of older people to the means test. We would violently oppose it.

Senator NICKLES. You would violently oppose it?

Mr. LAVICTOIRE. Strongly oppose it.

Senator NICKLES. Any type of means test whatsoever?

Mr. LAVICTOIRE. Most older people, few older people apply for welfare. We do not want the idea. Most of us have worked hard all our lives. Some of us have saved enough to get about. Immediate

income to older people is about $11,500. Most older people have incomes of less than $12,000 a year. Very few have incomes about $25,000 a year.

Senator NICKLES. If the means test was instituted so that those with an income at or below $11,000 would not pay as much as they are paying now? In other words, some people with annual incomes of $10,000 are having a hard time paying the medical expenses. So if their cost share was reduced and those with large incomes above $100,000 had their costs increased, would you oppose that?

Mr. LAVICTOIRE. I would not oppose a means test for anyone with $100,000 or more.

Senator NICKLES. So you would support a means test, depending on where the line is drawn?

Mr. LAVICTOIRE. Right, exactly.

When you get to that, you will have a hard time finding many older people. The point is unless we approach the problem of cost realistically, we just put a little Band-Aid, a little aspirin. We believe in competition. We would like to see it occur. But the point is we think that something needs to be done right now

Now, we would also like to see considerably more study done on the voucher system. Also on no fault insurance because there are many pros and cons to both. We would like to see both aspects studied before coming to any conclusion about them. But, for the time being, we think there is not accurate knowledge.

Now, as far as the future is concerned, we are just as concerned about the children and grandchildren. For ourselves, the future is not that long. We are almost in the same case as the older man I know who was approached by one of your zero coupon salesmen who tried to sell him a coupon that would mature in 2011. And the old man resisted and resisted, and the salesman finally looked at him and said what is the matter? Are you not interested in the future? He said, son, I do not even buy green bananas.

Senator NICKLES. If our next panelists will come up, the hospital panelists.

Cleveland Rodgers, our first panelist, and Tommy Thompson and James Harvey.

STATEMENTS OF CLEVELAND RODGERS, PRESIDENT, OKLAHOMA HOSPITAL ASSOCIATION, TULSA, OK; C.T. "TOMMY" THOMPSON, M.D., CHAIRMAN OF THE EXECUTIVE COMMITTEE, ST. FRANCIS HOSPITAL, TULSA, OK; AND JAMES D. HARVEY, ADMINISTRATION, HILLCREST FOUNDATION/HILLCREST MEDICAL CENTER, TULSA, OK

Mr. RODGERS. Thank you, Senator.

I will make mine very brief in the interest of time. I am Cleveland Rodgers, president of the Oklahoma Hospital Association.

I am glad to report to you today Oklahoma hospitals have made some progress during the past year in stabilizing the amount of increase in hospital costs. More progress than we have made in the past decade. We estimate by 1984 that the increase will be less than 7.8 percent over 1983. Compared with about 10. 6 percent, the Secretary reported earlier this week for the national picture.

The Medicare prospective pricing system for hospital inpatient acute operating costs provides very strong incentives for hospital and medical staff to reduce the length of stay, as well as the number of admissions if they are medically appropriate.

I want to report to you that it is working in Oklahoma. Our hospital admissions are down considerably from 7 to 10 percent. Our length of stay has been reduced almost 1 day this year. And with these reductions, we have surplus hospital beds in Oklahoma. Therefore we would urge that the Congress give some consideration to amending the swing bed legislation to apply to all hospitals regardless of the size so that we could take certain of the long-term care patients that have a special need, and as well as further to help us stabilize and reduce our inpatient costs.

I will say that the major problem affecting Oklahoma hospitals, of course, is the increased amount of bad debts and charity that we are facing. The cost shifting has already been talked about. It is getting more and more acute. We have already noticed in the last 3 years even a large amount of people who are coming to the hospital without adequate health care protection or inadequate insurance.

And we think the time has come, if we are going to deal with this cost shifting, is either that Medicare is going to have to include their proportionate share of the cost of charity patients a hospital must render, or they are either going to have to create incentives for broadening the Medicaid program to include some care for the medically indigent, rather than just the identifiable indigent, where we have them.

Whereas, most of the metropolitan and regional hospitals have been able to adjust their costs to permit them to fare well financially under the new Medicare and Medicaid prospective pricing system, Oklahoma rural hospitals, who receive the lowest DRG payments than any hospitals in the United States.

One of our rural hospitals, as you know, Senator, has already filed for bankruptcy. And we have about eight others that are in critical financial need. We would urge that the Congress expedite the movement of the DRG prospective payment to the national level as soon as possible, or rather than the regional. Those are the high points.

Thank you very much.

Senator NICKLES. Thank you very much.

Senator DURENBERGER. I just want to pay attention to the last thing. In 2 years we are going to need your help.

Senator NICKLES. Thank you very much.

Next panelist, C.T. Thompson, M.D. and chairman of the executive committee at St. Francis Hospital.

Dr. THOMPSON. My name is C.T. Thompson. I am a practicing general surgeon. I do have some administrative responsibility at St. Francis Hospital, and some long involvement at the State and local and national levels, particularly in regard to emergency medical services and trauma.

The purpose of this hearing is to discuss reform of the Nation's health care system, universal concerns of the American citizens about the increasing cost of medical care are apparent.

The challenge of the present is to see that our aging population and the general public itself will benefit from the modern advances in medical care. There is little doubt that there must be some type of cooperative planning between the medical profession and the hospital industry, the Government third-party payers, and the representatives of the American public.

It should be stated, at the outset, however, that all change that is implied in the word "reform," is not progress. And the working parts of the system should not be overthrown for the sake of reforms.

Tulsa is a proud community, with a very proud medical record. It is the largest community in the United States without a city, county, State, university, or Government hospital. All indigent care, as well as uncompensated medical care, is of serious concern. Hospital revenues come from patient care. The cost shifting inherent in medical care for the nonpaying patient, and the partially covered patient, presents a dilemma to the institution under pressure from the Government, third-party payers, and business coalitions who simply do not wish to share in the cost of indigent care, medical education, et cetera.

All the hospitals in Tulsa have responded to the cost concerns implicit in the prospective payment system by forming, or planning BTO's, HMO's, IPA's, or other joint efforts between hospitals and medical staff. Quality obtainment and peer review, as well as a marked shift to the outpatient environment are a part of that mechanism, and are already in place.

The Blue Plans, Aetna, Metropolitan and other third-party carriers have plans in Tulsa with primary emphasis on cost control, as well as quality. There are a number of concerns which we have, however, which must be addressed.

No. 1, the quality of care be given at least the same consideration as cost cutting. No. 2, that problems associated with maloccurrences in medical care must be addressed in a litigious society. And such a societal problem cannot just be solved by the health profession.

I would suggest that the legal profession literally feasts on the malpractice problem. Somehow our Congress, most of whom are lawyers, might look at a tort reform, no fault insurance, and limitation of the astronomical awards as a part of its responsibilty to society.

No. 3, who will pay for the indigent and uninsured and uninsurable? No. 4, who will study the health programs of regional scope that do not easily fit into ERG payment schemes?

Examples of this are reflected in neonatal, dialysis, trauma, cancer, heart transplants, certain of the rehabilitation programs. Technical capabilities alone in liver and heart, lung transplantations are presently there. But the problems are solvable, but the cost is high.

And should the Government decide to pay, as it does on the dialysis problem, there is little doubt that transplantation alone could bankrupt the entire medical system.

Epidemic problems, such as trauma, which is a leading killer under the age of 42, simply is not addressed in most Government programs.

No. 5, who will regulate the health entrepreneurs in four profit organizations, who skim the profitable, and dump the poor, and complicated? Patient care, education and clinical research have traditionally been the responsibility entrusted upon our health care system, which is generally voluntary, and nonprofit. Payment for this has been historically through NIH grants, Medicare reimbursement formula, and now some passes through provisions in the current payment scheme.

Should that mechanism change, so that health care, education, clinical research can only be funded by patient care dollars?

I would suggest that either medical education or the programs related to research will die, or the institutions will die. The responsibility rests with the Congress to provide alternate funding mechanisms for these types of efforts.

Perhaps the four profit organizations might wish to share some in this responsibility. There is little doubt that Government emphasis on cost cutting will succeed because there is a finite sum which will be allocated to health care Government dollars.

However, after all of the fat is trimmed from our medical system, then the rationing of services must start. The medical moral and ethical problems associated with who receives services, who pays, and who decides, must be met squarely by our lawmakers.

Thank you very much for the opportunity to testify.

Senator NICKLES. Thank you very much.

James Harvey, administrator for Hillcrest Foundation.

Mr. HARVEY. Thank you, Senator Nickles, and Senator Durenberger.

As indicated, I am James Harvey. I have been engaged in hospital administration in Tulsa since 1951. I am also a member of the board of trustees of the American Hospital Association. And several years ago I served as chairman of the American College of Hospital Administrators, which is a cosponsor of this study.

And I am gratified to see this is being used as the background for this very important hearing.

Tulsa is a microcosm of what is going on in the health care in the United States. The things we are doing in some areas of health care delivery here in Tulsa you could say are ahead of the Nation, while probably we are behind in others.

As has been mentioned, we have the PPO's, HMO's, IPA's, neighborhood clinics, a large ambulatory care system for indigent and medically indigent citizens, which has not been mentioned yet, Emergi-Centers, Urgent Care Centers and alternate birthing centers, all of those things that have occupied public attention for the past several years.

HMO's did not exist here 4 years ago. Now, 3 percent of the SMSA, which there are about 350,000 employees here, are enrolled. I realize that tails to Minnesota, Senator Durenberger, but projections are, for the next few years that is going to increase dramatically here in Oklahoma.

For years we have been plagued with the problem of financing care for the poor. It is music to my ears to hear the Senator observe how innovative and how directly we have come to grips with this problem here in Oklahoma. We believe that we have the potential of a model system for the care of indigents, if everybody in

this room, and Senator Nickles, particularly, vote for State question 575 on November 6.

The institutional heart of the Tulsa health care delivery system rests in several large tertiary care facilities in the metropolitan area. And those hospital roles have been changing dramatically. And in the interest of time, I am not going to try to belabor all that. They have been responding, that is the best I can call it.

We knew, we thought, that we had too many hospital beds before the current Federal change in payment systems took place. Now we know we got too many beds. Utilization of inpatient hospitalization has dropped 10 percent in 1 year. Discharges are down 5 percent. Recently a local newspaper reported the declines in the average lengths of stay of a half a day to 2 full days in Tulsa hospitals.

We have not been standing idly by, wringing our hands, as we watched this dramatic change. Traditional inpatient hospital beds have been rededicated through other kinds of uses that are more productive. Self-care, chemical dependency, substance abuse, those sorts of things. We are very aggressively getting into alternative forms of health care delivery. And those have already been enumerated, and I am not going to go through that.

One hospital has experienced 75 percent increase in ambulatory surgery, just in 6 months. Another, starting a home health care program earlier this year, is making 500 home visits a month, after only 3 months of operation.

So a lot of things are going on. There is a lot of turning. Part of the—one of the bad aspects of this, however, is that we have 1,500 fewer full time equivalent employees in Tulsa's hospitals than we did just 2 years ago.

Now, 1,500 on a basis of 10,000 total employees, means a 15 percent reduction in the employee force in our hospitals. This, in and of itself, of course, creates other kinds of social and economic problems. But as a result of that, and as a result of other cost containment initiatives, I can tell you that health care cost escalation per patient today has stopped dead in its tracks, and has gone backward in Tulsa, OK.

The cost for delivering the care has gone down, and the prices have not only stayed the same, but in many cases have been reduced.

Senator NICKLES. Would you mind repeating that? I want to make sure the camera gets that.

Mr. HARVEY. Health care cost escalation per inpatient case has dropped. The prices that we charge have not only stopped, but in many specific instances have been decreased, in the past year. There are a lot of hospital administrators out here that I think would be glad to acknowledge this is the case.

The one area of inpatient service that persists in growing is in long-term care and rehab. This is consistent with national trends, and reflects the general aging of the population.

So while the Federal Government anguishes over the increasing percent of GNP used for health care, it must not ignore the fact that it is destined to grow, for no other reason than the population is aging, and the chronic and degenerative disease incidence will increase, going along with that.

So I am saying that we must separate the problems before we can really discover the appropriate solutions. There is obviously not any one single solution to this whole thing.

Hospitals in Tulsa have very quickly brought their costs into line, but this is a major cost per case, as I said earlier, and not directly translatable to to total national expenditures for health care, which is a whole different kind of problem.

We have been energetic in developing more cost-effective alternatives for delivering care. In no way should hospitals be stifled from pursuing these multiple courses of actions.

On the other hand, we recognize the Government's problem, the growing deficits, the absolute maximum of the amount of money that can be dedicated for this purpose. Thus, one danger is that in our zeal to take directive action, we may throw the baby out with the bath water. And I am afraid that is a danger.

Now, Senator Durenberger, you already made my speech on all payers. And I am going to skip that. And I am going to get right down to the bottom.

While we look at the all payers, one of the quick fix—one of the quick fix approaches is that it is going to take care of indigent care. And that is not going to happen.

Why should we assume that Medicare, Medicaid will fund these costs, when presently they do not? And with the kinds of problems that face those programs, we got to look to sources external, to the current programs, and while we do, we must not abandon those institutions, large or small, urban or rural, which care for disproportionately large numbers of indigent clients, nor those which sponsor significant medical education programs.

Our best bet is to create financing systems relying on incentives to bring about behavior changes. And most consumer and providers, and we have heard some suggestions, as to what they might be, but they will work only if funding for those citizens, depending on the public sector, is adequate.

Safeguards, I am suggesting to you, are, or soon will be in place to assure that such public money will be spent in a cost-effective manner. Vote for 575.

Senator NICKLES. I heard that request twice and I plan on supporting it. And I also want to compliment those that have taken lead on issue.

Mr HARVEY. Just one point. When you hear people like Mr. Horkey get up here and testify, whose main business is not health care, and multiply that by a number of people who have genuine concern, and then get a relatively cooperative employer environment, then you see some of these things can take place.

[The prepared statement of Mr. Harvey follows:]

Statement by
James D. Harvey

HEALTH CARE ADVISORY COMMITTEE HEARING
Tulsa, Oklahoma
October 15, 1984

My name is James Harvey. At the present time, I am president of the Hillcrest Medical Center Foundation. I have been a hospital administrator in Tulsa since 1951. In 1983 I left active hospital management, but have remained with my institution to become involved chiefly with environmental issues which have an impact on my hospital. Without question, the major such environmental issue is the subject of today's hearing, which is the reason I appreciate being invited to testify. My involvement with such issues extends to the national scene. Currently, I am serving on the Board of Trustees of the American Hospital Association. I am a Fellow of the American College of Hospital Administrators and was Chairman of that organization a few years ago. It is gratifying that you have distributed as a background document the very significant study, "Health Care in the 1990's: Trends and Strategies," of which the College is co-sponsor and publisher.

Tulsa is a microcosm of what's going on in health care in the U.S. The things we are doing in some areas of health care delivery could be described as being ahead of the nation, while in other areas we are behind. On balance, we are, as I said, a microcosm. We have PPO's, HMO's, IPA's, neighborhood clinics, a large ambulatory care system for indigent and medically indigent citizens, emergi-centers, urgent care centers and alternate birthing centers. HMO's didn't exist here four years ago. Now three percent of the SMSA 350,000 employees are enrolled. Projections for the next few years indicate that there will be many more.

For years we have been plagued with the problem of financing care for the poor. Recent legislative initiatives have helped move us off dead center to the point where we believe some partial solutions are attainable. We have an opportunity to develop a model program worth emulating. This program and other cost control activities have been carried out between providers and the private sector through a business coalition and our Chamber of Commerce.

The institutional heart of the Tulsa health care delivery system rests in several large tertiary care hospitals whose role has been changing dramatically. Before current federal initiatives to change Medicare reimbursement practices to a prospective pricing system, it was generally acknowledged that Tulsa had too many hospital beds. Today we know we have too many. Utilization of inpatient hospital beds has declined 10% since last year. Hospital admissions have dropped 5%. Recently, a local newspaper reported declines in average length of stay from a half day to two full days in Tulsa's hospitals.

Hospital administrators have not been idly standing by wringing their hands as they watch this dramatic change. Traditional hospital inpatient facilities are definitely targeted for downsizing. Some beds have already been converted to other uses, e.g. chemical dependency and substance abuse units. Self-care units are being planned. While hospitals are facing a shrinkage in some traditional services, they have been very aggressively moving into new but related areas of health care delivery: ambulatory surgery, participation in urgent care centers, home health care, wellness programs and facilities, occupational medicine services and networking with outlying hospitals.

One hospital has experienced a 75% increase in outpatient surgery cases since last year. Another institution, after starting a home health care program earlier this year, was making 500 home visits a month after only three months of operation. Within this churning process, Tulsa hospitals' full time equivalent employed force has contracted. Today there are approximately 1500 fewer FTE's (full time equivalent employees) working in Tulsa hospitals than there were in 1982. On a base of 10,000 employees that represents a 15% decline. As a result of this and other cost improvement programs, health care cost escalation per inpatient case stopped in its tracks this past year.

The one area of inpatient service that persists in growing is in long term care and rehabilitation facilities. This is consistent with national trends and reflects the general aging of the population. So while the Federal government anguishes over the increasing percent of GNP being used for health care, it must not ignore the fact that it is destined to grow for no other reason than the population is aging, ergo, the incidence of chronic and degenerative diseases will increase.

We must separate the problems before we can discover appropriate solutions. Hospitals in Tulsa have very quickly brought their costs into line --- but this is a measure of cost per case and not directly translatable to total national expenditures for health care. Our hospitals have been energetic in developing more cost effective alternatives for delivering care. In no way should hospitals be stifled from pursuing these multiple courses of action. On the other hand, the resources of government are already less than can meet the growing demand for government supported health care benefits. Growing government deficits dictate that no relief can be expected from this source.

Thus, one danger is that in our zeal to take corrective action we may throw the baby out with the bath water.

I must raise a big "caution" sign to those who feel that a so-called "all-payers" system is the answer. First of all, it is unnecessary because we now have cost escalation under control, as I indicated earlier. Such efficiencies have been effected because of incentives, not regulation. Hospital management does not differentiate planning and production functions between its Medicare patients and others. The same advantages in control of Medicare costs by the DRG system are accruing to all purchasers of hospital care. Payments by these other purchasers should be allowed to develop from systems which take local needs into account. And, lest we forget, the DRG system, itself, has many flaws and unanswered questions. They are acceptable for the moment in the federal Medicare program because it seems to strike an equilibrium among competing and sometimes conflicting Medicare payment objectives.

Neither is an all-payer system an answer to the indigent care question. Why should we assume that Medicare or Medicaid will fund these costs when presently they do not? We must look to sources external to current programs. While we do, we must not abandon those institutions, large or small, urban or rural, which care for disproportionately large number of indigent clients --- nor those which sponsor significant medical education programs. Our best bet is to create financing systems relying on incentives to bring about behavior changes in both consumers and providers. But they will work only if funding for those citizens depending on the public sector is adequate. The safeguards are, or soon will be, in place to assure that such public money will be spent in a cost effective manner.

Senator NICKLES. Mr. Rodgers, you mentioned that your hospital charges have been reduced. Is that a result of competition between the hospitals in Tulsa and the fact that there are too many beds?

Mr. RODGERS. At first you got to recognize that we could not have operated at the level of the DRG that we were going to collect. So we had to take action. The old cost reimbursement system allowed us, as some people would refer to it, to get fat. And that is what we did. We just took the fat out of it, and the competitive element very definitely had something to do with it, because as you look into the future, if you do not compete with these various organizations, and so forth, that we have talked about, you are just going to be out of business.

We have to think that our hospitals in this city are worth preserving, and worth keeping. And I think that their response at most are not worthy. And I think that the future for health care in Tulsa are very, very, very sound and good.

Senator NICKLES. I would agree with that. Are hospital costs declining primarily through competition, or is it because of the existence of regulations, or through DRG's?

Mr. RODGERS. Well, I like to think that the DRG system is less regulation and more promotion. So the answer to the question, to both sides of that, just because DRG's apply only to Medicare, does not mean that the full positive effect of it does not spread throughout the entire hospitals. It absolutely does. So everything is getting the benefit of that.

Senator NICKLES. One final question: What do you think of the proposals which propose a much greater intrusion in price setting and regulation?

Do you feel like that is the trend that should be followed or not?

Mr. RODGERS. Well, I think that with the system that seems to be emerging, the price setting is occurring at the institutional level. And what we are doing is setting our prices to get the business.

Senator NICKLES. Through competition?

Mr. RODGERS. Through competition.

Senator NICKLES. Thank you very much.

Senator DURENBERGER. A quick observation.

In a way, I do not blame NARP for being apprehensive, because they went through voluntary cost containment in the late seventies. And you all were trying joint purchasing, and things like that. And for that two year period of time, when we were competing, Federal hospital cost containment, you know, you were doing pretty well.

But as soon as we had that beat, then the hospitals went right on up again. And it was not just the hospitals. Obviously, it was inflation. Inflation went up something like 46 percent over that four year period of time.

So in a way, I cannot blame them for being apprehensive, but what they failed to recognize, that all three of you recognize, is that if you think you got competition now, and empty beds, and underutilization, wait until the docs in this community really wise up, and start taking business away from you.

You know, and when they start saying, hey, I see something in that hospital we can do a heck of a lot cheaper, you know, that is the one that costs them a lot of money. We are going—that is the

one that makes the money. That is the one we are going to take away from them. That is what is happening. And when some of the enterprising doc's wake up to this, there is going to be even more competition at this level. And, unfortunately, AARP says they want choice and competition on the one hand. Then they want us to take money from Oklahoma and send it to New Jersey, you know, where the hospital costs are almost twice as much. Take money from Oklahoma to keep those costs high in New Jersey.

New Jersey is one of those public utility regulated States. And their costs increase twice as fast as the costs of Minnesota. And Minnesota is the competition State. Unfortunately, they just do not understand, I guess, what real competition is, the way you fellows can see it.

Thank you very much.

Senator NICKLES. Our next witness is David Bickham, executive director of Oklahoma Medical Association.

STATEMENTS OF DAVID BICKHAM, EXECUTIVE DIRECTOR, OKLAHOMA MEDICAL ASSOCIATION, OKLAHOMA CITY, OK; NORMON DUNITZ, M.D., PRESIDENT, TULSA MEDICAL ASSOCIATION, TULSA, OK; MICHAEL WHITWORTH, D.O., PRESIDENT, TULSA OSTEOPATHIC ASSOCIATION, TULSA, OK; AND RUDY WOLFE, D.O., SKIATOOK, OK

Dr. BICKHAM. As other panelists have, I would like to congratulate you, and thank you for having this hearing in Oklahoma.

Senator Durenberger, we do think we do things a little bit differently here. And we do think we do them a little better sometimes, too.

Our association represents over 4,000 medical doctors in Oklahoma, which is about 95 percent of the practicing physician population. We also, in addition to having a very large and active association, we also, Senator Durenberger, our own insurance company that writes malpractice insurance for physicians, so we have a very vested interest in what might happen at the congressional level, to malpractice.

We are, frankly, not very certain that there is a Federal role, but we are convinced that the major public policy decision must be made to change the direction that the cost of malpractice insurance is going, because it is fast becoming unbearable.

There are some parts of this country where a young physician, trained and very much needed speciality, has to pay as high as $50,000 a year to acquire adequate coverage for his practice.

Rather than going into a prepared statement, which I will furnish to you later, I would rather just comment on two or three items, and maybe give you some of your time back, Senator Nickles.

The problems of Medicare have been well articulated. I think since the attempt by Casper Weinberger in late 1970's with cost issue of the Medicare Program has been forced upon hospitals and physicians, I think we responded pretty well. Except obviously not enough has been done.

I do not believe that wage and price controls, forced assignment, hospital caps, I do not really believe that is the proper way to go.

They may be a temporary bond for the problem, but I think in the long range we have got to look for more lasting solutions. Competition is a frightening thing to some physicians. We are becoming a little bit more accustomed to it now.

As was mentioned earlier, we really have not seen it in this State for very long. But for the most part, I think we can live with competition, so long as there is an equal interest in cost and quality. I think the quality of medical care is really foremost in physicians' minds. And if we have to start compromising the quality of care in the interest of cost, it brings us to a real professional dilemma.

We recognize the problems our older citizens have in purchasing adequate care. And the fact that assignment rates in Oklahoma are not as high as they are in some other States, is not an automatic indication of our interest and our willingness to care for our older citizens.

Physicians in this State, to my knowledge, have never signed contracts with any insurer, contrary to many States, where they have contracts with insurance companies, and others. We just have not done that. Physicians make individual decisions on who and what type of payment arrangements they will make with patients. And we think that is a better procedure and process than in having automatic contracts.

Finally, let me just say I think the profession really would like to enter into a cooperative partnership with Government and business, in solving these problems. Undoubtedly, we have a major role in a service performed in that. We need some assurance, I think, from our Federal legislators, that they really are interested in that partnership. Our interest, and the reception that we got as a result of the PRO legislation, and the way that is being implemented, doesn't give us much confidence that the Government really wants a true, equal partnership with the profession.

The almost punitive nature in which that program has been put into play does not lend itself to, or indicate to us, that at least the Federal bureaucracy is interested in joint endeavor.

I think with those comments I will stop, and answer any questions that you might have. And I would say, the profession is very much interested in the solution to these problems. We very much are willing to participate with any organization.

We have to draw lines, I think, sometimes when we think that quality is being compromised at cost expense.

Thank you.

Senator NICKLES. Thank you.

We will ask all of our panelists to make their statements, and then we will ask questions.

The next panelist is Dr. Normon Dunitz. He is president of the Tulsa Medical Association.

Doctor Dunitz.

Dr. DUNITZ. I want to thank you, Senator Nickles, and Senator Durenberger, for being here and spending your time for something that is very close to the hearts of all physicians.

I, too, just flew in from Minnesota last night, and I brought with me what I hope you did not, what we used to call the Rochester flu.

The problem is, I think, apparent to all of us. But I want you all to know that the medical profession is made up of people of high ideals. There may be an occasional bad apple in our group, like in any group, but in general, doctors are concerned, probably more concerned, than any other group in the country. This includes the elderly.

I may be critical of the two of you, and I excused myself beforehand, if I do, but you were in the institution we call our Congress of the United States. The patient to us is a person. Mrs. Jones is a human being. Unfortunately, some of us perceive that Congress is treating these people as commodities, and not people.

I think we, the public, including physicians, accept the responsibility of all of us, that through our Government, we must provide some base care for the poor and the elderly.

On the other hand, I feel the elderly must realize that not everyone can drive Cadillacs. Unfortunately, in our perception, the Government has tried to be all things to all people. It just cannot be done.

As you peruse the legislation that has come forth over the past number of years, including the initial Medicare legislation, certain points become rather obvious, I think, at least to physicians who are helping, and want to take care of peoples' health.

The bed three is money, the budget, and political advantage. We do not see the concern for the welfare of Mrs. Jones. A simple obvious budget solution might be just to take the money you have, divide it, spend it in an equitable fashion, and say this is all there is.

I feel that our profession will rise to the challenge and cooperate with you in taking care of the people who need health and health care.

I would like to put certain challenges to you as Senators and Representatives of the Congress. I would like to demand that you and your colleagues raise yourselves above the act of trying to influence both from the electorate, and try to help Mrs. Jones. I would implore you to stop being politicians and become statesmen.

Less than one-fifth of the cost of health care is attributed to physicians' fees. Probably 90 percent of the rhetoric is placed in the newspapers in regard to this. I do not really mean to sound paranoid. You must treat the elderly as individuals. They are not cattle or commodities. They are individual human beings. Forget the pressure that self-serving lobbyists you meet in Washington work with those who are genuinely interested in the well-being of the public.

Our lives, the lives of practicing physicians, are really devoted to this goal. Our goals with you, too, who are spending your time in this effort, obviously run together. You should gain information from the people who are involved, and try to succumb to some sensible, logical conclusion that would not break the finances of our country, but will still provide the health care necessary to our people.

I apologize if I have been rude.

Thank you.

Senator NICKLES. You certainly were not rude. I appreciate your comments.

Our next panelist is Dr. Michael Whitworth.

Dr. WHITWORTH. I would like to thank you for inviting me here, and I am impressed with the concern you demonstrate. We are also concerned.

I represent the Tulsa District Osteopathic Society, and that is a rather unique situation, in that we are a minority profession, rendering health care. We are seeing a lot of new developments occur in the Tulsa region, and nationally, of course. And one of our main concerns is that as a minority profession we do not find ourselves on the outside looking in. That we are not excluded from rendering health care to those patients which we have treated in the past.

And with many of the situations that are developing, that is a potential threat. And we will assure you that we will render health care at competitive prices.

Certainly we share the concern about quality of health care. I would like to read just a little quote, "There is nothing in the world that some man cannot make a little poorer and a little cheaper."

And those who look at price alone, are his legitimate prey. Whenever we look for the prices, the bottom line quality is sure to suffer.

I would like to reassure the private sector here that we, as physicians, are remaining dedicated to rendering the highest quality of health care possible.

I was impressed with Senator Durenberger's remarks about the inverted method that we have used to practice health in the United States. We have always treated the disease, and never really focused our attention on prevention of disease. And I think that there will be untold millions of dollars saved if we spend more on health prevention programs. Think of all the money that could be saved if we could limit cigarette smoking in the United States, get people to moderate their drinking and eating habits, exercise properly, and use proper safety precautions to prevent accidents. I think that was a very good point that was brought up.

Senator DURENBERGER. I did not suggest that we had to stop everybody from smoking or drinking. Just that people who do not smoke and drink, should not have to pay for their smoking and their drinking.

Dr. WHITWORTH. I think we ought to stop smoking.

Senator DURENBERGER. I have got to throw my pipe away.

Dr. WHITWORTH. Briefly, I would like to address the issue of reform in medical malpractice. I think that is really a crying need in the United States today, and I really hope that you will take some responsible action in this concern. I think that some of the other points will be covered by other panelists

I thank you very much for your time.

[The prepared statement of Dr. Whitworth follows:]

COMMENTS BY MICHAEL H. WHITWORTH, D.O.

U.S. SENATE HEALTH CARE HEARINGS

Tulsa, Oklahoma October 15, 1984

Good morning, I am Dr. Michael H. Whitworth. As President of the Tulsa District Osteopathic Society and an active staff member and surgeon at Oklahoma Osteopathic Hospital, I appreciate the opportunity to participate in this health care hearing.

The Osteopathic community shares the concern of the health care consumers that changes must be made in health delivery to prevent the escalation of costs which threaten to bankrupt the Medicare Trust Fund.

Oklahoma Osteopathic Hospital and its physicians are striving on several fronts to contain costs. Specifically, I would like to mention the Osteopathic commitment to wholistic medicine and disease prevention; the leadership of Oklahoma Osteopathic Hospital in the use of outpatient surgery; the IPA-structured Health Maintenance Organization that we have launched; and, of great importance, the utilization review and quality assurance procedures that we have fine-tuned to help us implement the DRG program in the hospital.

It is appropriate to mention first the long-standing emphasis of Osteopathic Medicine on prevention as well as treatment. While all good doctors view

patients as a whole person—with mental and spiritual components as well as physical systems—we believe that it is the main stay of Osteopathy. Since its inception Osteopathic medicine has advocated the wholistic approach. And, while we have all the specialties represented among Doctors of Osteopathy, the general practice emphasis continues. About 75% of all D.O.s are in general and family practice. These doctors are in an excellent position to stress prevention and hold down medical costs by taking into account all aspects of a patient's lifestyle and serve as gatekeepers to the access of health services.

The Osteopathic Surgicenter, which is a free-standing structure on the Oklahoma Osteopathic campus, has proved to be a major success. Its usage has increased consistently since it was opened in the summer of 1982. The advantages of outpatient surgery are two-fold. First of all it is usually more pleasant and less stressful for the patient. Second, the cost savings are substantial when the patient can arrive for surgery in the morning and go home just a few hours later. Although the DRG program is now mandating that certain procedures be done on an outpatient basis, at Oklahoma Osteopathic Hospital we were moving in that direction much earlier. Yet, while I favor the outpatient surgery trend, as a surgeon I am uncomfortable with government guidelines that may prescribe it in some instances where the physician's judgement indicates that it is not in the patient's best interest.

Oklahoma Osteopathic Hospital began operating its Health Maintenance Organization in January of this year. It was implemented after close to two years of planning in which physicians were deeply involved. Since the hospital and the doctors have a vested interest in its financial success, great emphasis was placed on the close scrutiny of utilization. Substantial progress has been made. Our HMO is providing excellent care to its members but the physician members are also cooperating with our mission of curtailing any unnecessary treatment and excessive use of diagnostic measures. The combined effect of formal utilization review and peer pressure has been very satisfying.

Turning to the matter of the Federal Government's DRG Program, I believe that the hospital has approached it in a very positive manner. There most certainly are philosophical objections that can be directed at this concept--which increases government controls--but Oklahoma Osteopathic Hospital focused its attention on effective implementation.

We were fortunate to have in place an ongoing utilization review and quality assurance program that already has given us one of the best records of the Tulsa hospitals in respect to the average length of a patient's stay. That progress has continued since we went onto the DRG system at the start of the year.

Education has played an important role in our progress at the hospital. Meetings were held, and special materials issued, to help doctors,

department managers and other employees of all kinds from nurses to maintenance workers. There is perhaps a tendency to think that all health costs are the result of sophisticated treatments and diagnosis but that is certainly not true. In this era of DRGs and other cost trimming motivations there is no place for waste in any facet of a hospital's operation--whether it is in the intensive care unit, the business office or the kitchens.

While a patient is in the hospital a computer program that we devised keeps medical personnel alerted to the costs that have been incurred and how this relates to the DRG allowable for a given condition. Frankly, we believe that our DRG tracking system is one of the best in the state.

Tracking charges definitely does not mean cutting corners. We are able to work within the DRG allowables in most instances bu there certainly are times when the arbitrary nature of the system is very costly to the hospital. We recently were faced with providing over $170,000 of treatment for which the DRG fee was only $5,600. That pinpoints one of the problems of a system that does not properly take into account the severity of an illness. The hospital would most certainly encourage adjustments in the DRG approach. But, at the same time, we are going to continue our efforts to deliver excellent care while holding down costs.

Discharge planning is being given special attention. When a patient is admitted the process of planning for discharge begins at virtually the same time. Oklahoma Osteopathic Hospital has a discharge planning team that

prides itself on moving patients out of the hospital and back into their homes. A wide variety of hospital departments mesh their efforts to see that patients receive necessary home care and outpatient treatment after they are discharged.

To conclude my comments, the U.S. Department of Health and Human Services reported last week that in 1983 the annual increase in health care costs was the lowest in a decade--10.3%. This is encouraging but even more progress is needed if we are to preserve the financial solvency of our people and the Medicare Program. Oklahoma Osteopathic Hospital and its physicians are doing their part. We have operated in 1984 without raising charges.

Thank you for the opportunity to share these opinions with your committee.

Senator NICKLES. Thank you very much.

Our next panelist is Rudy Wolf, D.O., Skiatook, OK.

Dr. WOLF. Mr. Chairman, and Senator Nickles, thank you very much for asking me to be a part of this panel today.

I am Rudy Wolf, D.O., president-elect of the American College of General Practitioners and Osteopathic Medicine and Surgery.

I am also chairman of the Physician Manpower Training Commission of the State of Oklahoma. And I am a past president of the Oklahoma Osteopathic Association.

I have been in the active general practice of osteopathic medicine for 23 years, in a community of about 2,300 people. And a large portion of my professional life is spent in the care of the elderly.

My statement is somewhat lengthy, and I am going to capsulize it. So if I hesitate, I am shifting from one paragraph to the next.

The principles of osteophatic medicine recognize the tendency of the human body toward wellness, when all of its systems are functioning properly, and also stress prevention of disease.

Patient education and promotion of healthier life styles, combined with early diagnostic and health screening, were historically, and are today, major contributions of osteopathic medicine. Improved health care and longer productive life is the most effective means to reduce health care costs.

In addition, osteopathic principles emphasize the importance of primary health care. High quality health care provided by osteopathic physicians has allowed access to health care in previously underserved areas. Accessibility provides an alternative to costly inpatient care, and visits to expensive hospital emergency rooms.

Through the enhancement of the physician-patient relationship, D.O.'s learn, not only of the patient's medical needs, but also of

their ability to pay. These factors are considered on a personal basis when the physician determines how much to charge.

We realize that more must be done to insure that quality health is available to all Americans. Because of this concern the American Osteopathic Association Board of Trustees and House of Delegates has been studying physician reimbursement. And recently recommended a policy to change the way physicians are reimbursed. The position adopted supports an indemnity reimbursement plan, whereby a set benefit would be paid for individual services, rather than some arbitrary percentage of reasonable charges.

Physicians who feel that they have offered exceptional service may charge a higher amount than if provided in the indemnity. Thus, the marketplace and cost consciousness on the part of the patient and physician will determine a physician's total indemnity, or, excuse me, reimbursement. Consumers of health care will have the opportunity to become prudent purchasers, since they will be able to compare their physician's charges to the indemnity benefit.

We believe this will encourage physicians to compete, creating an incentive to lower their charges. Freedom of choice—freedom to choose a provider would be preserved under such a system such as this, because patients would receive the same benefits for service regardless of which physician provides it. Access to care would be improved as the incentive to practice in affluent settings is removed.

The indemnity benefit would be essentially the same, regardless of practice location. This system would be far simpler to administer, and the costs would be relatively predictable.

In summary, we believe this system to be equitable and compassionate, and one that deserves further study as an approach to reducing health care costs. There are many reasons, other reasons, why of course, medical health care costs are so high. And we have heard so many discussions on this today.

But physician payment and physician manpower needs and programs are areas that I am most familiar with. My expertise lies in the promotion of the delivery of high quality health care, and working with the problems of physician manpower needs, not insurance and financing.

So I cannot offer solutions to appease the concerns of the elderly nor the Nation. I can only offer my assistance to this subcommittee and to the Congress, as they look into the issue of how our health care dollars will be spent.

I will be pleased to respond to any questions, Mr. Chairman, that you may have.

Senator NICKLES. Thank you very much, Dr. Wolf.

Doctor Bickham, you mentioned the physician assignment rate in Oklahoma. What is that rate?

Dr. BICKHAM. No. I think someone mentioned this morning about 15 to 17 percent for this State, which will be low among the 50 States. But as I say, the assignment right does not necessarily mean, does not indicate, I do not think, the amount of care that is given to older citizens without charge.

In other words, and especially under the forced assignment system that Congress recently enacted, physicians opt not to be a participating physician under the Medicare. He still has the option

of taking assignment on every case, if he wanted to, you see. So that is not really very fair.

Senator NICKLES. Do you think the last statement you made is known? I have detected a lot of confusion throughout the State as far as whether or not physicians will be taking assignment on a case-by-case basis. Is that known?

Dr. BICKHAM. I doubt that that is well known at the moment. As you know, Senator, under the law the Health Care Financing Administration will have to publish a manual of those physicians that have indicated that they will take assignment on 100 percent of their cases. That directly, so to speak, will be made available.

I hope that that does not create a lot of confusion, because some physicians who are not listed there, who do take assignment on a case-by-case basis, their patients may look at that and say, wait a minute, my doctor does not participate in Medicare, when that is not the case at all.

Senator NICKLES. I appreciate your clarification on that. Before you leave, you and Dr. Dunitz mentioned a strong statement opposing mandatory assignment.

If I am correct, I believe Senator Kennedy, and several others, have proposed mandatory assignment.

Would you go into that issue a little bit further?

Dr. BICKHAM. Well, basically, it is philosophical, but not 100 percent. It is an economic, also. Statistics that I read recently show that our citizenry over age 65 have more disposable income than any other age group within our population.

Why should someone be forced to discount his bill without any consideration to the patient's ability to pay? It seems to me, and as I—the physician-patient relationship is distorted when that becomes an automatic feature. And I do not think that should be the case.

I think the physician and patient should talk, and if they have—if a patient has a financial difficulty, that should be taken into consideration. We have gone on public record many times saying we are going to take care of our older citizens regardless of what Medicare does.

Well, that is the case today, and I do not think we should just automatically require physicians. Why could not Blue Cross-Blue Shield do the same thing, or any other insurer?

Senator NICKLES. Thank you for your comments.

Doctor Dunitz, in your statement you mentioned the "political nature," of discussions regarding health care issues. Sometimes there is political abuse of this area. We have seen some of that in the elections this year, and in the past years. This is unfortunate. It should not be used as a political football.

People make statements about Medicare, Medicaid, or Social Security trying to scare one group into voting for them, or against another group.

The problems are too serious for that. It is important to look at the facts, recognize what the facts are, and then try to see what type of changes need to be made so that there is affordable and quality health care for our country, without trying to see how many votes you can pick up by making this statement or that statement.

Senator Durenberger.

Senator DURENBERGER. Very briefly on that point, I ran in 1982 under Republican, which was a lousy time for Republicans to expose themselves to the electorate. Nothing to it this year.

September of 1981, 14 months ahead of the time, 540,000 senior citizens in my State got an envelope from my opponent, who is a self-professed millionaire. The envelope you have all seen since then, and it just says, "Social Security information. Please open immediately." Some 540,000 trembling fingers ripped open envelopes, and found in there a condemnation of me as a Senator.

Now, fortunately, that hit me 14 months ahead of time, and I was able to talk with the seniors in my State about this problem. But the reality is, I happen to know more about some of these issues than a lot of other folks. And I suppose for that reason I was able to get by by the skin of my teeth. But a lot of other people are not, and Don makes the correct point, as long as there are a few politicians in this country that will use the elderly, and use their fears, it is going to be very, very difficult for any of us to deal with the subject of reform by whatever name you want to give it.

My concern, though, is that on the flip side of it, you know, if you look at the doctors, I will just read you the figures, and the population is not aging this quickly, but here is the history of Medicare part B benefit, which is the doctors and drugs.

My first full year in the Senate, 6 years ago, that total was $5 billion. This coming year it will be $18.3 billion. Now, that is a big, big jump in a relatively brief period of time. So I think you would have to acknowledge that it is not us saying doctors have to give a little in this system.

It is because we here, constituents out there, look at, you know, the price of physician services, in part B going from $5 billion 6 years ago, to $18 billion today. And somebody is saying, hey, wait a minute. That is a little bit more than inflation has gone up in that period of time.

So I, obviously, am curious to know how, in Oklahoma, the physicians would feel about an expansion of the prospective payment system in Medicare. I do not like this mandatory assignment, and I do not like it for other reasons. And that is, good doctors cannot get paid more. The idea that you ought to have everybody paid the same thing bothers me.

I hope we can move quickly through this thing, because even this DRG is regulatory. But given that, the doctors, I think, are going to have to adjust, or look at the reality of expanding this prospective payment system to include doctors, nursing homes, home health, hospitals, some of these other things, the medical association has a view on whether in this transition period it would be better to be part of this prospective payment system, than to go to mandatory assignment.

Dr. DUNITZ. Well, it is a little difficult. We do not have a policy position as of today on that subject. We were very concerned when the DRG system was implemented for hospital payment services, because the early indications of that were that it was discriminatory to a large extent.

As we have gone along now for a few months, or almost a year, with prospective payments in the hospitals, there does not appear to be cause for alarm at this point.

Senator DURENBERGER. But we could give you cause. We could ratchet those prices down.

Dr. DUNITZ. That is the kind of concern, Senator, we would have about the physicians' side of it, because he who holds the handle of the wrench—

Senator DURENBERGER. That would be your apprehension.

Dr. DUNITZ. One thing, Senator Durenberger, that is an example of some of the stories we get; $5 million for doctors' fees 4 years ago, to $15 or $18 now. You must realize why it is $18 billion now. You have to include the reason for these things.

We have technology now that was not available 4 or 5 years ago. Inflation has gone up. Personnel costs are higher. Just to make statistical analysis without reasons for it is not serving the cause you are trying to serve.

A PANELIST. Could I comment on your paper?

On page 2, table 2, there is a summation of physician fees as it relates to the total health care. And it was something like 24.1 percent of a dollar in 1960. And it is 21.5 percent of a dollar in 1982. That is a decrease of about 11 percent.

Senator NICKLES. We appreciate your comment.

Our final panel is next, with the first panelist being Michael Fogarty, the assistant director for medical services for the Department of Human Services in Oklahoma City.

STATEMENTS OF MICHAEL FOGARTY, ASSISTANT DIRECTOR FOR MEDICAL SERVICES, OKLAHOMA CITY, OK; RICHARD McCUTCHEN, SENIOR VICE PRESIDENT OF MARKETING, BLUE CROSS-BLUE SHIELD OF OKLAHOMA, TULSA, OK; AND PAUL COOPER, SENIOR VICE PRESIDENT, PRUCARE, OKLAHOMA CITY, OK

Mr. FOGARTY. Thank you very much, Senator Nickles.

Chairman Durenberger, we appreciate your presence in Oklahoma here today, as well.

I was asked to participate in this hearing today, to present some information regarding Medicaid programs. I am indeed grateful for the opportunity to testify on the critical issue of health care in this State, and in this Nation.

What I have to say today is presented with the sense of guarded optimism. The force of my optimism is the evidence of growing public awareness and concern about health care in this country.

The fact that this hearing is being held is itself evidence of that concern. And certainly, the attendance at this hearing is additional evidence.

We have seen additional evidence in the State of Oklahoma, as in its last session, as you mentioned, Chairman Durenberger, the Oklahoma Legislature passed legislation which is to be a vehicle to provide payment for indigent health care. Access to primary health care, the spiraling costs of medical services, provision of newly developing highly technical and expensive medical procedures, such as organ transplantation, and other health issues, cut across State boundaries, and call for a national response.

The issues transcent partisan lines, as well.

Chairman Durenberger, as you mentioned, your colleague on the Finance Committee from Oklahoma, Senator Boren, has received, and has been given bipartisan support for needed improvements in Medicaid statutes.

The chairman of the House Budget Committee, Congressman Jim Jones, in whose district we sit today, continues from the leadership position, to address health care as the highest priority issue to our Nation in these times.

The Federal and State Medicaid programs is the principal vehicle for financing health care services to poor people that is the center of this issue. It is, perhaps, appropriate for the subject of Medicaid to be included in a panel of insurers, and other third-party payers of health care benefits.

In many respects, Medicaid is not unlike other third-party payrolls. Within Federal guidelines, States establish criteria to determine what individuals are to be covered by the program. We determine what types of medical services are to be covered, and the extent of that coverage. We determine allowable rates of payment to be made for those services. And we process claims for payment to health care providers.

The Medicaid Program that Oklahoma seniors receives an average of 2,500 to 3,000 provider claims per day, processing 1 million claims this past year.

In other respects, however, Medicaid is quite different from other payers. Medicaid is obviously publicly funded, not by premiums paid by those who are covered, but by tax dollars, both the State and Federal level. Those of us who administer the Medicaid Program must be accountable to the taxpayer for those expenditures.

The public accountability, itself, often results in cumbersome procedures, and results in frustrations, for those who need medical assistance, and face complicated eligibility requirements. As well as for those who provide services on the face of the maze of billing forms and requirements in order to be paid.

The most basic difference is that beneficiaries, or recipients of Medicaid do not gain this coverage because they choose to join the group plan, or otherwise purchase coverage, or receive it as a benefit of their employment. They are covered due to financial destitution, coupled with other circumstances beyond their control. Young age, old age, or disability.

For this reason, I hope my testimony today reflects not only my perspective as an administrator of Medicaid, but as a State and Federal taxpayer. Most importantly, I wish to speak on behalf of the Medicaid recipient and indigent, those even though financially destitute, fall from the Medicaid eligibility crack, with no resources to purchase needed medical care.

The Medicaid Program in Oklahoma is not untypical of those in other States. In State fiscal year 1984, just ending last June 30, $426 million was paid for Medicaid services. Of that $426 million, 35 percent was paid for hospital services; over 9 percent for physicians' services; 43½ percent for nursing home services; 7 percent for in-home health care, known in Oklahoma as the nontechnical medical care; over 3½ percent for prescribed medication, and 2½ percent to purchase Medicare benefits on behalf of those who re-

ceived cash assistance in Oklahoma, and for other miscellaneous items.

Between 65,000 and 70,000 Oklahomans received Medicaid services in any given month; 200,000 people received services this last year. The magnitude of the financial issues become apparent when the 1984 expenditures of $426 million are compared to 10 years ago, when in 1975 the total medical outlays in Oklahoma were $155 million.

Medicaid costs increased at a rate of 15 percent per year, from 1975 through 1982. Nearly doubling in 5 years, from 1975 to 1980, and increasing again by a full one-third of that total in 2 years, from 1980 to 1982. Then came the budget crisis, in 1983, reduction in Federal financial Medicaid support, coupled with a shortfall in State revenue, drove a series of cost cutting measures.

At the risk of oversimplifying, I suggest to you that there are only three ways to quickly reduce the cost of this program. Tighten eligibility, so as to reduce the number of people being served. Reduce or eliminate the types of services provided, or reduce the amount paid to medical providers for those services.

In the winter and spring of 1983, Oklahoma froze nursing home rates at the January 1982 level. Froze physicians' allowable charges at the 1983 level, not passing through the 5.5 increase granted to physicians under Medicare. We granted no increase in the pharmacy dispensing fees. We eliminated coverage of Medicaid part B deductible in insurance charges. We modified the hospital payment system from the Medicare cost reimbursement system to a prospective per diem rate system.

As you can see, virtually all of these actions were directed at provider reimbursement levels.

Senator NICKLES. I am going to have to interrupt because we are running out of time. I want everyone to have an opportunity to make their statements, as well, so I apologize for stopping you at this point. We will enter your entire statement in the record.

Mr. FOGARTY. Thank you, sir.

[The prepared statement of Mr. Fogarty follows:]

TESTIMONY OF MICHAEL FOGARTY
ASSISTANT DIRECTOR FOR MEDICAL SERVICES
OKLAHOMA DEPARTMENT OF HUMAN SERVICES
HEARING ON REFORMING OUR NATION'S HEALTH CARE SYSTEM
DON NICKLES, U. S. SENATOR
DAVID DURENBERGER, U. S. SENATOR
TULSA, OKLAHOMA - OCTOBER 15, 1984

I was asked to participate in this hearing today to present information regarding the Medicaid Program. I am indeed grateful for the opportunity to testify on the critical issue of Health Care in this state and this nation. What I have to say today is presented with a sense of guarded optimism. The source of my optimism is the evidence of growing public awareness and concern about health care in this country. The fact that this hearing is being held is itself evidence of that concern. Additional evidence was seen when the Oklahoma Legislature, during its last session, passed legislation which is to be a vehicle to provide payment for indigent health care. Access to primary health care, the spiraling costs of medical services, provision of newly developing, highly technical and expensive medical procedures such as organ transplantation, and other health issues cut across state boundaries and call for national response. The issues transcend partisan lines. As you mentioned, Chairman Durenberger, your colleague on the Finance Committee from Oklahoma, Senator Boren, has received and has given bi-partisan support for needed improvements in Medicaid statutes. The Chairman of the House Budget Committee, Congressman Jim Jones, in whose district we sit today, continues from his chairmanship position to address health care as one of the highest priority issues for our nation in these times. The federal-state Medicaid program, the principal vehicle for financing health care services for poor people, is at the center of this issue.

It is perhaps appropriate for the subject of Medicaid to be included in a panel of insurers and other third party payors of health care benefits. In many respects, Medicaid is not unlike other third party payors. Within federal guidelines, states, like private insurers, establish criteria to determine what individuals are to be covered by the program. We determine what types of medical services are to be covered and the extent of that coverage. We determine allowable rates of payment to be made for these services and we process claims for payment to health care providers. The Medicaid Program in Oklahoma receives an average of 2500 to 3000 provider claims per day - processing 1 million claims this last year.

In other respects, however, Medicaid is quite different from other payors. Medicaid is obviously publicly funded, not by premiums paid by those who are covered, but by tax dollars at both the state and federal level. Those of us who administer the Medicaid Program must be accountable to the tax payers for these expenditures. This public accountability often results in cumbersome procedures and results in frustration for those who need medical assistance and face complicated eligibility requirements, as well as for those who provide services and face a maze of billing forms and requirements in order to be paid.

The most basic difference is that beneficiaries (recipients) of Medicaid do not gain this coverage because they choose to join a group plan, otherwise purchase coverage, or receive it as a benefit of employment. They are covered due to their financial destitution coupled with other circumstances beyond their control -- young age, old age, or disability.

For this reason, I hope my testimony today reflects not only my perspective as an administrator of Medicaid, but as a state and federal taxpayer. Most importantly, I hope to speak on behalf of Medicaid recipients and those who we have come to call "medically indigent" - those who, even though financially destitute, fall through the Medicaid eligibility cracks with absolutely no resources to purchase needed medical care.

The Medicaid Program in Oklahoma is not atypical of those in other states. In state fiscal year 1984, ending June 30, 1984, $426 million was paid for Medical Services. That $426 million was expended as follows:

Hospital	$145 (million)	34%
Physician	39	9.2%
Nursing Home	185	43.4%
In-Home Non-Technical Medical Care	30	7%
Prescription Drugs	16	3.7%
Medicare Premiums & Other	10	2.4%

Between 65,000 and 70,000 Oklahomans receive Medicaid services in any given month. 200,000 people received services this last year. The magnitude of the financial issues becomes apparent when the 1984 expenditure of $426 million is compared to 10 years ago, when in 1975 total Medicaid outlay was $155 million. Medicaid costs increased at a rate of 15% per year from 1975 through 1982, nearly doubling in the 5 year span, 1975 to 1980, and increasing again by 1/3 of the total in 2 years, from 1980 to 1982. Then came the budget crises of 1983. Reductions in federal financial Medicaid support coupled with a short fall in state revenue drove a series of cost cutting measures. At the risk of oversimplifying, I suggest to you that there are only three ways to quickly reduce the cost of this program: 1) tighten eligibility so as to reduce the number of people being served, 2) reduce or eliminate the types of services provided, 3) or reduce the amount paid to medical providers for those services. In the winter and spring of 1983, we froze nursing home rates at the January, 1982 level, froze physician allowable charges at the pre-July 1, 1983 level - not passing through the 5.85% increase granted physicians under Medicare, granted no increase in the pharmacy dispensing fee for prescribed drugs, eliminated the coverage of Medicare Part B deductible and co-insurance charges, and modified the hospital payment system from the Medicare cost-reimbursement system to a prospective per diem rate system.

As you can see, virtually all of these actions were directed at provider reimbursement levels. The result of these changes reduced the rate of growth from approximately 20% between 1981 - 82 to under 2% between 1982 - 83. Although the recipients, state agency and even the providers appear to have survived that initial round, future reductions of this magnitude will require much deeper cuts in numbers of recipients served and services provided.

I am pleased to report that during this period of quick and sometimes dirty budget cutting, there was also much work done on developing other options for longer term savings. Oklahoma has taken advantage of recent federal changes which allow expanded coverage of prenatal care. Evidence abounds that a relatively small investment in adequate prenatal care will reap future benefits by avoiding costly complications resulting in savings both financially and in human terms. We are also pressing for federal approval of home and community based care waivers

which will enable us to shift future resources from growing institutional and in-patient services to more appropriate and less costly home and community services. Any assistance you can give us in obtaining approval of these waivers would be appreciated.

I would like to turn for a moment to the Health Care/Medicaid issue on a bit broader base. It was my good fortune about two years ago to be invited to participate with eight of my colleagues throughout the country in what is now known as the National Study Group on State Medicaid Strategies. The project was staffed by the Center for the Study of Social Policy in Washington, D. C. and supported by the Robert Wood Johnson Foundation. The group set out to establish an agenda for change in health care programs with two primary goals--1) control of rapidly rising costs and 2) improving access to and quality of needed health care services. The group's recommendations were published in January, 1983, and those materials have been provided to your staff for the record. We explored a range of alternatives from statutory modifications of the current program to total restructuring of federal-state health care programs. It was our conclusion that to be responsive to today's health care issues, to attain the goals of cost containment and access to quality care, and to overcome current problems in the Medicaid Program, will require basic reform and restructuring of the system. Such restructuring will require major changes in both the health care delivery system as well as in the administration of publicly administered health care program.

The Medicaid Program, as conceived and implemented some twenty years ago, was designed to be jointly administered and funded, through a partnership if you will, between the federal and state governments. This partnership approach, I am sorry to say, has degenerated into one in which the federal administrators view their primary role as that of recovering federal funds from states through audits, penalties and sanctions. I was shocked to hear a high ranking federal official announce recently that the federal-state partnership is dead. At this same meeting, the federal officials provided documents which ranked several key federal organizational units, scoring each on the ratio of federal funds recovered from states compared to salary costs of each unit. Two weeks ago, Senator Nickles, Oklahoma received a notice of federal disallowance of a quarter of a million dollars. This disallowance was based on a federal finding that certain required physician certifications were not valid since the date appearing on the document was not written in the doctor's own handwriting. A typed date was found not to meet a requirement for the physician to "sign and date" the document. I may spend more than the disallowance fighting this one in federal court. States, on the other hand, have increasingly viewed Medicaid as a vehicle through which to raid the federal treasury, finding ways to draw federal matching dollars for state expenditures. Unfortunately, the current relationship diverts our energies and resources away from helpful and positive cooperation and instead to frequent battles and often to the courthouse in litigation. This strikes me as absurd, irrational and counterproductive.

Medicaid has other basic structural problems which make it less than effective in meeting today's health care needs. Its deeply rooted biases toward institutional and in-patient services and for fee for service and cost reimbursement payment systems add to the difficulties of today's program. Probably the most critical

limitation of the program is its linkage to cash assistance programs for recipient eligibility. When Medicaid was orginally enacted, I can imagine that it made sense to avoid creating a program with its own separate eligiblity requirements. The primary purpose of the program was to provide access to health care for poor people. Congress opted to simply provide that if an individual was eligible for cash assistance, he or she was automatically eligible for medical assistance.

Unfortunately, this eligibility linkage not only involves financial eligibility limits (income and resources), but also limits Medicaid coverage to only those who relate to specific categories of cash assistance programs; e.g., Aid to Families with Dependent Children (families with children deprived of financial support due to absence or incapacity of a parent) and Supplemental Security Income (individuals who are 65 years of age or older and those who are totally and permanently disabled as defined by the Social Security Disability programs). This means that individuals who are between the ages of 21 and 65, who have no children at home and who are not totally disabled, are categorically excluded from Medicaid regardless of their financial destitution. These are the people to which I referred earlier as "medically indigent." You have no doubt heard of the classic example of the 55 year old widow, financially destitute, no children at home, not yet 65 years old, not totally disabled, and totally without resources, either public or private, for obtaining necessary medical care.

Let me share with you another example of the Medicaid "gap" with which I dealt recently. This case involves a young man with hemophilia. Since birth, he has required blood clotting factor at an annual cost of $6,000 to $8,000 and frequent hospitalization. Due to his family's financial circumstances, much of the cost of his care and treatment had been covered by Medicaid. During this particular hospital stay, however, he learned that a significant event had occurred - he had recently celebrated his twenty-first birthday. It was at this point he learned that since he was no longer under age 21 years, he was no longer eligible for Medicaid. None of his personal circumstances, financial or medical, had changed except for his age.

Public policy underlying health care programs in this country was interpreted to this young man by his case worker. The worker explained that since he no longer related to the AFDC Program (as a child under 21 years), his only hope of continued Medicaid assistance was to apply and be certified for Social Security Disability. Further, he was advised that his part-time job and college attendance would probably be viewed by Social Security as evidence of his ability to "engage in substantial, gainful activity" in which case he would not be found to meet "total disability" requirements. This young man explained to me, in words more eloquent than mine, that the government was telling him that the only way for him to receive life-supporting medical services, is to abandon all attempts at independence and productivity and attempt to convince the Social Security Administration, if not himself, that he is totally disabled, and dependent on the government assistance not only for expensive medical services, but in all other areas of his life. Unfortunately, the categorical eligibility requirements of Medicaid produce exactly that result.

As financial eligibility requirements for cash assistance programs have been tightened over the recent past, the continued use of these standards for medical assistance eligibility has become even more irrational. For example, the current limit of $1500 in liquid assets may be appropriate for cash assistance eligibility. It is questionable that such a limit is realistic for medical assistance.

For these reasons, and others identified in the Study Group's report, it is our recommendation, and my personal recommendation to you today, that we pursue basic reform of publicly funded health care programs. Such reform should be guided by a premise that essential, primary health care services are to be equally available to all Americans, not dependent on State of residence. A Primary Health Care Program should ultimately be available based on financial means standards independent of cash assistance programs and their categorical restrictions. It must include basic changes in the health care delivery system and payment mechanisms, utilizing more efficient pre-payment, capitation, and case management approaches rather than the fee for service and cost-reimbursement systems of today's program.

A separate program to support the elderly and disabled in their need for long term, or "Continuing Care," services should be established outside the Primary Care Program. This program would include services ranging from nursing home care to that mix of social and medical services provided in the home and community and should encourage the use of these alternatives to institutional care. A program for continuing care services is better suited for state and local administration, with flexibility to meet the unique needs of this population. These services would need and deserve the commitment of federal support through block grant funding with state/local participation.

It has been said today that Medicaid was effective in accomplishing its goal of providing access to health care for poor people - it has, indeed. It is not a time to curse Medicaid. It is a time to thank it, bind it in fine leather and put it on the shelf along with other programs that have made great contributions to the progress of this country and its people. It is now time to move ahead, restructuring public health care to meet needs of today and the future.

Today's health care issues are of obvious interest and concern to you. Your commitment to health care programs is encouraging, and for that I thank you.

Senator NICKLES. Thank you.

Our next panelist is Richard McCutchen, senior vice president for marketing for Blue Cross-Blue Shield of Oklahoma.

Mr. MCCUTCHEN. I think one of the factors that will allow me to abbreviate my comments is that what you have heard already from the panelists representing consumers and hospitals, and physicians, is that what we have in Oklahoma, we believe, is a fairly dynamic and emerging marketplace, and competitiveness and creativity. And it has resulted in very positive steps, and the results of those have been very positive.

In reading the health options document, I was struck by two or three things that I think need, I guess, consideration. And that is, principally, is to attempt to avoid a simple solution to a problem that is very complex.

You can go down the list of various programs, and they do not have often simple solutions. You must recognize the response time necessary to effect these solutions is very great in an industry that consumes over 10 percent of all of the country's resources. And perhaps the best direction for us to take, is to use marketplace incentives that are already existing, and let them be the factor that governs the direction that we take.

And, finally, maybe from a regulatory standpoint, be concerned about the marketplace framework, and the regulation that exists, and try to simplify it, to encourage the innovation that is necessary to make a system work effectively.

From the insurance industry perspective, we deal with trying to deal with this problem and relate it to our customers, which are principally groups and individuals that want products they need. And they have a very real desire for two things, and that is, lower rates and a cost containment type of environment.

And in order to respond to that, not only Blue Cross, but the insurance industry in general, whether it is Prudential or Aetna, has had to respond with more leadership. People doing something to help out in giving direction to reeducate groups, to reeducate individuals on what is needed, which is principally to get away from first dollar coverages, and to move toward benefit packages which provide this incentive, which cause individuals to use the least expensive level of care.

Do that, what we have developed, and I think it is becoming more commonplace, is our principal product is a comprehensive product that has no deductibles less than $200. But in addition to that, to compliment that, we have major portions of that product, have no deductibles, or coinsurance, if you use those types of services.

For example, outpatient surgical procedures, those done, there is no deductible. We waive that for other things, like three dimension testing, second surgical opinions, hospice care, home health care, nursing facilities, those kinds of things that do direct patients for the right level of care, for what amount to cost containment, or what really is rate-containment type programs.

Blue Cross, and I think as you will hear from my colleague who will follow me, has moved into alternative delivery systems, because that is an important part of presenting to the marketplace, through the insurance industry, HMO's, PPO's, and really, the pro-

posal for a triple option type, where you can choose one of those options to meet your insurance needs.

And in addition to that, we at Blue Cross have implemented an innovative payment system since January of this year. And that is also tending to positively influence the way care is delivered. And it does affect average length of stay, and charges per claim. And those are being positively affected.

We have the same under normal cost containment type programs, but what you will see more of over the next few years is movement toward cost containment type programs, preadmission certification experiments, stay well activities, I think we will see more of that.

Early maternity discharge programs, or various other approaches. But the marketplace is going to be one of redesigning programs, and adjusting to those programs.

And my concluding comments would be that we should, at a minimum, attempt to let the marketplace dictate what benefits should be, we should move away from a trended mandated benefit. We should secondarily look at our statutes, to make sure that they are in fact not impediments to the development of alternate delivery systems. And generally rely on the dynamics of the vigorously emerging marketplace on competition, on creativity, and believe that that will do more than mandating programs from above because they really are not the simple solution that some would lead us to believe.

Senator NICKLES. Thank you very much.

Our next, and final panelist, will be Paul Cooper, senior vice president of PruCare from Oklahoma City.

Mr. COOPER. Thank you, Senator.

I was asked to describe the experience of HMO's in the State of Oklahoma. I will do that briefly.

PruCare started developing the State's first HMO in Oklahoma City in the summer of 1979. Over 5 years ago. At that time there was some concern, and some resistance, and quite a bit of misinformation about HMO's among the physician community. Many opinion leaders in the physician community openly expressed opposition to prepaid medical care. At the same time, there were a smaller number of physicians who were extremely receptive to the idea of giving the prepaid concept an opportunity to demonstrate that it could deliver quality health care affordably.

PruCare located and developed agreements with a sufficient number of physicians who felt this way, to get a program organized and licensed, and began operations in concert with the central Oklahoma medical group in April 1981.

The acceptance of the State's first HMO by consumers, businesses, unions, and government, was extremely enthusiastic. The program exceeded its enrollment projections for its first 2 years.

In many groups to whom it was offered, participation varied greatly, in some it was as high as 40 percent. And in many groups, those shares have increased since then.

The year 1983 saw the expansion of the HMO concept to Tulsa. PruCare teamed up with the Medical Care Associates of Tulsa to begin operations on January 1. Two other HMO's, Health Care Choice and HMO of Oklahoma, also began operations on that date.

And even more Tulsans joined HMO's the first year they were available, than had been the case in Oklahoma City.

In 1984, two more HMO's, Health Care Plus in Oklahoma City, and TAKECARE in Tulsa, entered the market. And at the present time, well over 50,000 Oklahomans have chosen to receive their health care through one of the six HMO's operating in Oklahoma City and Tulsa. At least three more are actively in the process of development and licensure.

Have these programs met the objectives of providing quality health care cost-effectively? Speaking from PruCare's experience, we are very pleased with the track record. While HMO premium rates, like other medical care expenses, have increased over the years, the growing number of consumers who elect this option in a highly priced competitive market indicates that the working people feel this is a good buy.

With respect to quality, our medical groups in both cities are very pleased with the caliber of physicians they are able to recruit. They principally recruited physicians trained or residing in Oklahoma, and both groups restrict membership to highly qualified, residency trained, board-certified, or board-eligible physicians.

And the supply of physicians able to meet these rigorous qualifications, and interested in HMO practice, is quite adequate. And the availability of highly qualified consultants in both medical and surgical subspecialties to whom our groups refer has been quite satisfactory.

The advent of competitive medical programs into Oklahoma has brought a certain amount of conflict and concern. This was to be expected in a system dominated by a single method of payment for so long. Many attitudes have changed, however, since 1981. Most physicians now seem to have accepted that HMO's and other types of prepaid health care alternatives will be very much a part of the scene in Oklahoma, and that it will be the marketplace that ultimately chooses which methods of financing and delivery survive, and which methods predominate.

I will skip through the comments on the proposals, and go to a short general observation, if I may. An expression of concern, some of these proposals are regulatory in nature, and some are market-oriented.

In recent years, our national health policy has sought to embrace proposals that draw upon both philosophies. Occasionally, these approaches come into conflict.

For example, the imposition of the all-payer hospital rate regulation in New Jersey, in the form of BRG's, has raised controversy because of what many feel is a negative effect on HMO's in other competitive plans. Future decisions on health policy must look very closely at regulatory proposals, such as hospital rate regulations, to insure that they do not hinder competition and innovation, and that they impact equitably upon the various types of entities that exist within our increasingly pluralistic system.

The incentives are in places never before for health care providers to deliver a product that is not only of high quality, but affordable. And those who pay for health care—businesses, consumers, unions, and governments—are demanding that this happen.

I think there is evidence that the providers and the third-party payers are responding. The test of competition as an effective force for restraining costs is just beginning on a large scale. And I think that allowing that test to run its promising course should be one of our highest priorities.

Thank you.

[The prepared statement of Mr. Cooper follows:]

REMARKS ON HEALTH CARE REFORM OPTIONS

Paul P. Cooper III
Senior Vice President
PruCare of Oklahoma

I would first like to describe the experience of HMOs in the State of Oklahoma. PruCare began developing the state's first HMO in Oklahoma City in the summer of 1979. At that time there was some animosity, resistance and misinformation regarding HMOs among the physician community. Many opinion leaders in the physician community openly expressed opposition to prepaid medical care. At the same time, there were a smaller number of physicians who were extremely receptive to the idea of giving the prepaid concept an opportunity to demonstrate that it could deliver quality health care affordably. PruCare located and developed agreements with a sufficient number of physicians who felt this way to get a program organized and licensed, and begin operations in concert with the Central Oklahoma Medical Group on April 1, 1981.

The acceptance of the state's first HMO by consumers, businesses, unions and government was extremely enthusiastic. The Oklahoma City HMO exceeded its enrollment projections for its first two years of operation. In the initial offerings of the HMO to groups of working people in Oklahoma City, participation varied greatly, but in many groups, as many as 40 percent of the employees elected the HMO as an alternative to traditional health insurance the first time it was offered. For the most part, those shares have grown even larger in the three and one-half years that Oklahoma City has had an HMO.

1983 saw the expansion of the HMO concept to Tulsa. PruCare teamed up with the Medical Care Associates of Tulsa to begin operations on January 1. Health Care Choice and HMO of Oklahoma also began operations on that date, and even more Tulsans joined HMOs the first year they were available

than had been the case in Oklahoma City. Health Care Plus in Oklahoma City and TAKECARE in Tulsa have entered the market during 1984. At the present time well over 50,000 Oklahomans have chosen to receive their health care through one of the six HMOs operating in Oklahoma City and Tulsa. At least three more are actively in the process of development and licensure.

Have these programs met the objectives of providing quality health care cost-effectively? Speaking from PruCare's experience, we are very pleased with the track record. While HMO premium rates have increased over the years, the growing number of consumers who elect this option in a highly price-competitive market indicates that the working people feel this is a good buy. With respect to quality, our medical groups in both cities are very pleased with the caliber of physicians they are able to recruit. They have recruited physicians trained and/or residing in Oklahoma, and both groups restrict membership to residency-trained, board certified or board eligible physicians. The supply of physicians able to meet these rigorous qualifications and interested in prepaid group practice is quite adequate. Also, the availability of highly qualified consultants in the medical and surgical subspecialties to whom our groups refer has been quite satisfactory.

The advent of competitive medical programs into Oklahoma has brought some opposition and conflict. This was to be expected in a system dominated by a single method of payment for so long. Many attitudes have changed, however, since 1981. Most physicians now seem to have accepted that HMOs and other types of prepaid health care alternatives will be very much a part of the scene in Oklahoma, and that it will be the marketplace that ultimately chooses

which methods of financing and delivery survive and which methods predominate.

Now with respect to the proposals for health care reform, I will make some broad comments. One of the things the HMO experience demonstrates very forceably is that the driving factor most directly influencing health care costs is physician behavior. Many other factors, including health status of the population, benefits design, payment system, limitations on capital expenditures, etc., have an impact. The effectiveness of any proposal to contain health care costs, however, will depend ultimately on its ability to affect the behavior of physicians and other providers who utilize costly medical resources.

Of the proposals mentioned in the discussion paper, self-insurance has perhaps the least impact on health care costs because, unless other changes are made, it has no effect on the behavior of medical providers.

Proposals to give the consumer a stake in the cost through tax caps or deductibles and copayments will have some impact, to the extent that consumer demand does influence services ordered by physicians.

Changes in the way providers are compensated such as DRGs under Medicare will also have some impact in my opinion, since this has caused hospitals to analyze physician behavior and look at the economic outcomes. Hospitals have had little or no incentive to do this in the past.

HMOs and other prepaid comprehensive medical care plans that furnish a total range of services and compete on price with other alternatives will have a very significant impact

on the cost of health care. These plans must have cost-effective behavior from their medical providers if they are to be able to satisfy the marketplace on the issues of both price and quality.

I will conclude with an expression of concern. Some of these proposals are regulatory in nature and some are market-oriented. In recent years our national health policy has sought to embrace proposals that draw upon both philosophies. Occasionally, these approaches come into conflict. For example, the imposition of hospital rate regulation in New Jersey in the form of DRGs has raised controversy because of what many feel is a negative effect on HMOs. Future decisions on health policy must look very closely at regulatory proposals such as hospital rate regulation to ensure that they do not hinder competition and innovation, and that they impact equitably upon the various types of entities that exist within our increasingly pluralistic system.

The incentives are in place as never before for health care providers to deliver a product that is not only of high quality but affordable. Those who pay for health care -- businesses, consumers, unions and government -- are demanding that this happen. There is evidence that the providers and the third party payors are responding. The test of competition as an effective force for restraining costs is just beginning. Allowing that test to run its already very promising course should be one of our highest priorities.

Senator NICKLES. Thank you.

You mentioned that 50,000 people in the State of Oklahoma are now participating in the HMO?

Mr. COOPER. About 56,000. I do not have totally up to date information on all the HMO's.

Senator NICKLES. What percentage of that would be elderly?

Mr. COOPER. I can only speak for our program in Oklahoma City, about slightly over 100 of our members in Oklahoma City. And that is considerably a smaller percentage than in the general population now. Now that the HMO contract and regulations have been issued by the Health Care Financing Administration, the rules are beginning to become clear. And that has been what the HMO industry has been waiting for, as to what the arrangements will be for alternate Medicare population.

I think we are very close to seeing a high degree of participation by HMO's in the Medicare Program.

Senator DURENBERGER. Do you have a PruCare plan to go into the market?

Mr. COOPER. No, we do not have a contract with the Health Care Financing Administration. We are in discussion with them. And that is our aim. We do not have anything that will happen January 1.

At the present time, like I said, we did have members over 65 who joined as active or retired employees of the group, but that is a small number. We do not access Medicare on a large scale until we have a contract. We are in discussion with them on that.

Senator NICKLES. But you do not see a contract for next year?

Mr. COOPER. Certainly not by January 1, 1985. During 1986, it is a possibility.

Senator NICKLES. Thank you very much.

Mr. McCutchen, you mentioned a lot of the changing programs. A lot of people in this room, I am sure, are consumers, purchasing Blue Cross.

We have also heard from the hospitals; the hospital costs have declined in the Tulsa area. What has happened to costs of premiums for individuals in the last 2 years?

Mr. MCCUTCHEN. Well, I think that there was a great deal of premium shock that existed in 1981 and 1982 and 1983, as a result of our misguessing how much health care would cost. So there was a little bit of doubling up. That has moderated. In fact, from a marketing standpoint, it will also please me to know that we look at our larger groups as they get renewed, the number of them that have no increase in their right.

So, care, and their pattern of the use of the care is very good. And that has been exceptionally obvious on the benefit packages that have this incentive built into them. The rate of increase in health care, all those things are positive factors. And they are being reflected now in more moderate increases.

We have become accustomed to this, it is the second year in a row. It looks very favorable.

Senator NICKLES. I hope that is the case. I know Senator Durenberger and I receive letters from people who basically give the summation that they are insurance broke.

I know that there have been dramatic escalations of cost. We have all talked about that. And, of course, that is reflected in the higher rates, as well.

Thank you very much.

Mr. Fogarty, you administer a very large and complicated program. Is there anything that you would like for Congress to do to assist you? You mentioned a few people falling through the cracks.

Mr. FOGERTY. Absolutely, and it has been referred to by people appearing earlier today. There people we call indigent, that is a structure gap problem, Senator, with Medicaid.

My conclusion is simply this: I do not think there is a way for you as a Member of Congress to put enough patches or enough Band Aids, if you will, on the current Medicaid Program to make it a responsive program to today's health care needs. I think the Medicaid as has been said earlier has done exactly what it was intended to do. It has provided access to health care for poor people who otherwise do not have it. I do not think we should curse it. I think we should thank it. I think we should bound it in leather and put it on the shelf. I think we should move on in a basic structural reform for this Nation's health care system. I have given to your staff for the record some specific recommendations for national reforming or restructuring the delivery system, and I would hope that you would have the opportunity to look at that.

Senator NICKLES. OK, thank you.

Senator DURENBERGER. Maybe curiosity, do you have any plans now if the voters are as smart as Senator Nickles and are going to support this extra initiative here in November, do you have plans for utilizing some of the other alternatives to buy services for Medicaid?

Mr. COOPER. Absolutely. As a matter of fact, unfortunately I was able just to complete the bad news and not really talk about the good news. While we have done some fairly quick, and frankly dirty budget reducing activities in the last several months, we have also spent a great deal of time looking at relatively small investments in areas such as prenatal care, which we are convinced pay big dividends and savings both financially and in terms of human lives. Alternatives to institutional and inpatient care, we have submitted waivers. That is one thing in response to your question, Senator, if you could help us get the Federal Government to approve our present request for waivers under the home community-based services, under the provisions of the Federal law, that would be appreciated.

We are also working very closely and specifically here in Tulsa, as Senator Durenberger, with those who are taking leave. And I think you made a point very well earlier that it is really not the Government that can lead in that kind of delivery system revision. It is a sector out there that you will see and hear more about today in Tulsa. It is a coalition.

Senator DURENBERGER. Do you have any contracts right now?

Mr. COOPER. No.

Senator DURENBERGER. Is that in your course of your duties?

Mr. COOPER. I anticipate we will be able to do that.

Senator DURENBERGER. How many employees get a choice of an HMO?

Mr. COOPER. None.

Senator NICKLES. To all of our panelists and all the witnesses that we have had today, I want to thank you very much for your patience, especially in allowing me to prod you along. I am appreciative of your interest and participation. It is indicative of the fact that there are a lot of Oklahomans that are concerned about the quality and cost of health care and what can be done to solve the problems.

And a special thank you to my colleague, Senator Durenberger, for coming all the way from Minnesota today.

[Additional material supplied for the record follows:]

STATEMENT OF

RUDOLPH J. WOLF, D. O., FACGP

PRESIDENT-ELECT OF THE AMERICAN COLLEGE OF GENERAL

PRACTITIONERS IN OSTEOPATHIC MEDICINE AND SURGERY

AND

CHAIRMAN OF THE PHYSICIAN MANPOWER TRAINING COMMISSION

OF THE STATE OF OKLAHOMA

AND

PAST-PRESIDENT OF THE OKLAHOMA OSTEOPATHIC ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

SENATE FINANCE COMMITTEE

ON

HEALTH CARE REFORM OPTIONS

OCTOBER 15, 1984

Thank you, Mr. Chairman, and members of the Subcommittee for permitting me to participate in this forum today discussing Health Care Reform Options. I am Rudolph J. Wolf, D. O., President-elect of the American College of General Practitioners in Osteopathic Medicine and Surgery, and Chairman of the Physician Manpower Training Commission of the State of Oklahoma and a Past-President of the Oklahoma Osteopathic Association. I have been in the active general practice of osteopathic medicine for 23 years and devote a large portion of my professional time to the care of the elderly.

Let me begin by explaining what an osteopathic physician is and some of the contributions osteopathic medicine has made to health care in America. Founded some 110 years ago, due to dissatisfaction with the type of medicine being practiced at that time, osteopathic medicine developed the principle that every patient should receive complete health care. The osteopathic approach to treatement stresses care to the entire person, not just to the symptom or illness; because what happens in one part of the body can affect other parts. Physical, mental and emotional well-being, as well as nutritional needs and environmental factors are all important considerations in a doctor of osteopathic medicine's diagnosis and treatment. Doctors of osteopathic medicine are referred to as DOs and are licensed to practice medicine and surgery in all states along with their MD counterparts.

Today there are more than 21,000 osteopathic physicians providing complete health care to 35 million Americans. More than 90 percent of our physicians are providing primary care, thus reflecting our emphasis on general practice and family medicine. Over half of all osteopathic physicians practice in communities with less than 50,000 people, frequently delivering health care to families in rural areas. As one of the fastest growing medical professions, there are over 200 osteopathic hospitals located in 31 states and 15 colleges of osteopathic medicine.

The principles of osteopathic medicine recognize the tendency of the human body toward wellness when all its systems are functioning properly and also stress prevention of disease. Patient education and promotion of healthier life styles, combined with early diagnosis through health screening, were historically, and are today, major contributions of osteopathic medicine. Improved health and longer productive life is the most effective means to reduce health care costs.

In addition, osteopathic principles emphasize the importance of primary health care. High quality health care provided by osteopathic physicians has allowed access to health care in previously underserved areas. Accessibility provides an alternative to costly inpatient care and visits to expensive hospital emergency rooms. Through enhanced physician/patient relationships osteopathic physicians learn, not only of the patient's medical needs, but also about the patient's ability to pay. These factors are considered on a personal basis when the physician determines how much to charge.

Seeking to ensure that the standardsof high quality health care are uniformly maintained, the osteopathic profession has supported an active program of peer review. Physicians reviewing the work of other physicians, we believe, is an effective means of making sure the best care is provided in an appropriate setting.

As cost effective as these efforts have been, we realize more must be done to insure that quality health is available for all Americans. Census Bureau data shows that by the year 2000 the U. S. population will increase by 14%,but the 65 and over population will grow by 28%. Projecting to the year 2000, it is expected that one of every eight persons will be 65 or over. Discussions, combined with study and experimentation, are necessary to develop new methods of health care delivery. We, as a profession, are concerned about the growing demands of service to the elderly population and are seeking solutions to meet these needs. It is our firm belief, that any method must assure quality of medical care and freedom of choice of physician and hospital.

Because of this concern the American Osteopathic Association Board of Trustees and House of Delegates has been studying physician reimbursement and recently recommended a policy to change the way physicians are reimbursed. The current system of third-party reimbursement, based on usual, customary and reasonable (UCR), many experts agree, has fueled the acceleration of health care costs by driving up fees. Both the recipients and the physicians are disenchanted with the insensitivity and unpredictability of payments. The position adopted supports an indemnity reimbursement plan whereby a set benefit would be paid for individual services; rather than some arbitrary percentage of reasonable charges. Physicians who feel that they offered a patient "exceptional services" may charge a higher amount than is provided by the indemnity. Thus the marketplace and cost-consiousness on the part of the patient and physician will determine a physician's total reimbursement. Consumers of health care will have the opportunity to become prudent purchasers, since they will be able to compare their physician's charges to the indemnity benefit. We believe this will encourage physicians to compete, creating an incentive to lower their charges.

Freedom to choose a provider would be preserved under such a systembecause patients would receive the same benefit for service, regardless of which physician provides it. Access to care would be improved as the incentive to practice in affluent settings is removed; the indemnity benefit would be essentially the same regardless of practice location. The system would be far simpler to administer than the current system and annual costs to the government and insurers would be relatively predictable. In summary, we believe this method to be equitable and compassionate and deserves furthur study as an approach to reducing health care costs.

In reviewing the paper prepared at the direction of Senator Nickles, I feel I must callto the Subcommittees' attention a conclusion I reached from Table 2 on page 2. In 1960, physician services represented 24.1% of each health care dollar spent and 22 years later, in 1982, physician services represented 21.5% of each health care dollar spent. This is a decrease of 11%.

An observation of Table 3 on page 3 is also noted. Between 1965 and1982, public dollars expended for health went up 12 times, while private dollars expended for health went up 6 times. Percentage wise, the public sector increased from 26% to 42%, while the private sector dropped from 74% to 58%. I would ask several questions:

Does the ratio of public dollars to private dollars influence health care costs?

If yes, how?

What lessons can be learned from this and applied to the future?

What is the percent of health care dollars spent in both the public and private sectors on administration of programs?

There are many other reasons for the high cost of medical care; but physician payment and physician manpower needs and programs are areas I am most familiar with. My expertise lies in the promotion of the delivery of high quality health care and working with the problems of physician manpower needs and programs, not insurance and financing. I cannot offer solutions to appease the concerns of the elderly and the Nation, I can only offer my assistance as this Subcommittee and Congress look into the issue of how our health care dollars will be spent. I would be pleased to respond to any questions, Mr. Chairman, that you may have.

(....and if you would permit me I would like to add a few personal observations, mostly antedotal and from hands on experience. I have observed as a country or rural physician in a small community of 3500, and one who cares for three and four generations of the same families that there is a growing concern among my patients, many of whom I visit in their homes on house calls, or social visits and whom my family socializes with and share concerns within the community, that there is over the past few years a growing concern among my elderly patients and their dependents about loss of access to medical care due to fairly low fixed incomes of which a larger share is being spent on health care.)

(My friends, my patients, complain about the ever increasing premiums, deductables, and costs of medications and worry if God and Congress will provide the funds should they be unfortunate enough to live and be unable to provide self-care or home care and be forced into a high cost institution. They don't know or understand the financial problems of the Social Security Trust Fund or understand the complexities of governmental financing of health care. In some respects I am glad they do not as they do not need this added anxiety and stress. We as a society and as a government have led the people to expect that after a life of work and financial contributions to this country that we would insure financial health security in the years when it is most needed. This is the perception of the people. The people hope that you in the Congress are blessed with the wisdom of Solomon and the patience of Jobe and look to you and the medical profession to provide the magic bullet to relieve their strain. I want you to know that the physicians and hospitals I work with are willing to work with you to find maybe not a magic bullet but some simple solutions to complex health problems that affect employment and health.)

(We know your job is difficult. We realize that the problem is not yours, but ours. We want to work in cooperation with you, the Congress, to find ways, and there are ways, to cut health care costs while maintaining quality and allowing our needy citizens to maintain their dignity. We stand ready to assist you and invite you to seek our consultation and expertise on an ongoing basis, as time today does not permit a great amount of dialogue.)

TMHC, Inc.

TESTIMONY PRESENTED AT

PUBLIC HEARING OF U.S. SENATE

HEALTH COMMITTEE

Tulsa, Oklahoma
October 15, 1984

Honorable Senators - Dave Durenberger and Don Nickles

The following testimony is respectfully submitted by the Tulsa Mental Health Council.

A recent study of the National Institute of Mental Health estimates that 1 in 5 Americans is in need of mental health care and suffers from some degree of disability.

In Tulsa County, based on national studies, we would anticipate that:

4,789 persons would suffer from schizophrenia . Currently, the voluntary system is caring for approximately 1,900 or barely half of these disabled persons. This illness is characterized by poverty, lack of appropriate occupational training and a tremendous need for a wide range of care that is community based, both because a much wider variety of care can be offered and because it is more cost-efficient.

95,780 persons would suffer from other emotional illnesses and problems of substance dependence. Currently only about 4,100 persons are cared for in the voluntary system.

In Tulsa County, 55% of all law enforcement arrests are due to problems with drugs or alcohol. This includes "drinking under the influence", arrests for public drunkeness, and arrest for the illegal use or selling of drugs.

2,882 arrests for driving under the influence

5,388 arrests for public drunkeness or intoxication

1,591 arrests for drugs

9,861 total arrests

TULSA MENTAL HEALTH COUNCIL INC.
1574 EAST 21ST STREET, TULSA, OKLAHOMA 74114, 918-744-7646

Any significant reduction in the abuse or misuse of such substances would significantly reduce law enforcement costs.

The Tulsa City-County Jail currently houses 26,000 persons a year. Of these, it is estimated that approximately 60%, or 15,600, suffer from mental disability, severe emotional problems or substance misuse and abuse. Of these, 8,100 are between the ages of 18 and 30 years of age.

The economic, social and health consequences of this number of citizens unable to provide economically for themselves or their dependents is catastrophic.

We would urge the federal government to continue to take leadership in the following areas.

National programs of health promotion and within health promotion initiatives encourage the abatement of the misuse of alcohol and chemicals and the promotion of emotional well being.

That problems of substance abuse and mental disability receive the amount of research attention, particularly applied research in serve delivery innovation at the local and regional level.

That with severely debilitating problems, the federal government encourage innovations in offering a much wider array of interventions at the neighborhood level in order to make it as easy and acceptable for citizens to request and make use of services early on in their difficulties.

Thank you.

Respectfully submitted,

Barbara Ann Allen, M.S.W., M.Ph, Ph.D.
Tulsa Mental HealthCouncil

BAA:mc

TULSA COUNTY MENTAL HEALTH SYSTEM

FACT SHEET

SERVICES INDICATORS

4 Community Mental Health Centers

1 Agency devoted to planning & 24-hour Crisis Stabilization

*Patients have increased from 2900 to 6249 since 1979

7 Satellites (hope to expand to 9 FY 84-85)

TARGET POPULATION INDICATORS

17 Medication clinics per week

3 Day Treatment Programs

2 Transitional Living Programs

Tulsa County serves 25% more Chronically Mentally Ill than statewide average
-Tulsa County 41%
-Statewide 31%

ECONOMIC INDICATORS

Patient population tripled since 1980 Funding has barely doubled.

**Cost per person dropped from $805 to $768 since 1979 (decrease of 4.5%)

Cost per person served dropped from $805 to $559 when adjusted for inflation (31% decrease)

***General health care costs rose 74% during same time period

Cuts in appropriated funding range from 3% to 20% during past year

****Per capita state appropriations:
-Tulsa County $5.62
-State Average $8.66

****Tulsa County's funding is 35% less than the statewide per capita average.

* Based on close estimate SFY 1984.

** Based on Consumer Price Index.

*** Based on Health Care Financing Review Forecast.

**** Based on ODMH contracts and Oklahoma Health Planning Commission Population figures.

Family Medical Clinic
of Nowata

Robert C. Bowman M.D.

Family Medicine

DIPLOMATE
AMERICAN BOARD OF
FAMILY PRACTICE

708 EAST OSAGE · P.O. BOX 392
NOWATA, OKLAHOMA 74048
(918) 273-0140

Rural Health Care Issues

Given the present course of government cutbacks in reimbursements and stricter regulation of the health care delivery system, the existence of present Rural Health Care systems is threatened. Many hospitals (the foundation for many of these systems) are expected to falter and close. Due to decreased availability of these entry points to the health care system, the quality of health care can only suffer. Those who have a critical need for emergent care may die as a result as these hospitals are no longer there to provide initial care to trauma or heart victims. The most devastating result will be the effect on the social and economic fabric of the community (hospitals are a focal point of the area and provide 60 jobs and 3 million of local economy in Nowata alone).

What course would you have those of us who are interested in maintaining and improving rural health care pursue?

1. Petition for higher reimbursements and fee profiles from Medicare and Medicaid? (Bucking the present trend entirely - not likely)
2. Apply for Community Health Service grants and aid to replace the Health Care services that we are losing in failing hospitals and exiting doctors? (taking years and also lots of federal dollars)
3. Plan to move away as the hospitals die and find greener, more crowded suburban pastures, leaving the rural elderly, poor, and disadvantaged behind? (obviously we who came to serve choose this option only as a last resort) Just as it takes the elderly two or three days to recover for every day spent lying in bed, so will it take rural areas two to three times as long to recover from any setbacks due to changing health care.

Doctors share a credo with all professionals, be they minister,teacher, or legislator. All of us were taught to do no harm! We all know that changes must be made, but rural areas must be protected by you from the serious harm that is now occuring. Please ask these questions of any proposal including the ones now enacted:

1. Does it make health care more available?
2. Do the people doing the care really care?
3. Is it equitable to the care others get?
4. Lastly,is it cost-effective(after the above)

We know you agonize over the consequences of your actions, please just keep us in mind.

Senator NICKLES. This meeting is adjourned.

[Whereupon, the subcommittee recessed to reconvene subject to the call of the Chair.]

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